Copy Application

Life House, LLC

CN1301-001

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STATE OF TENNESSEE 8 AM 11 51
HEALTH SERVICES AND DEVELOPMENT AGENCY

500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
615/741-2364

INSTRUCTIONS FOR FILING AN APPLICATION FOR A CERTIFICATE OF NEED

Please read the following instructions, the Rules and Regulations of the Agency, and Tennessee Code Annotated, §68-11-1601 *et seq.*, prior to preparation of this application.

DOCUMENTATION: In preparing this application, it is the applicant's responsibility to demonstrate through its answers that the project is necessary to provide needed health care in the area to be served, that it can be economically accomplished and maintained, and that it will contribute to the orderly development of adequate and effective health care facilities and/or services in this area. Consult Tennessee Code Annotated, §68-11-1601 *et seq.*, Health Services and Development Agency Rule 0720-4-.01, and the criteria and standards for certificate of need document Tennessee's Health: Guidelines for Growth, for the criteria for consideration for approval. Tennessee's Health: Guidelines for Growth is available from the Tennessee Health Services and Development Agency or from the Agency's website at www.tennessee.gov/HSDA. Picture of the Present is a document, which provides demographic, vital, and other statistics by county available from the Tennessee Department of Health, Bureau of Policy, Planning, and Assessment, Division of Health Statistics and can be accessed from the Department's website at www2.state.tn.us/health/statistics/HealthData/pubs_title.htm.

Please note that all applications must be submitted in triplicate (1 original and 2 copies) on single-sided, unbound letter size (8 x 11 ½) paper, and not be stapled nor have holes punched. Cover letter should also be in triplicate. If not in compliance as requested, application may be returned or reviewing process delayed until corrected pages are submitted.

REVIEW CYCLES: A review cycle is no more than sixty (60) days. The review cycle begins on the first day of each month.

COMMUNICATIONS: All documents for filing an application for Certificate of Need with the Health Services and Development Agency must be received during normal business hours (8:00a.m. - 4:30p.m. Central Time) at the Agency office, located at 500 Deaderick Street, Suite 850, Nashville, TN 37243. For the purpose of filing Letters of Intent, application forms, and responses to supplemental information, the filing date is the actual date of receipt in the Agency office. These documents, as well as other required documents must be received as original, signed documents in the Agency office. Fax and e-mail transmissions **will not** be considered to be properly filed documentation. In the event that the last appropriate filing date falls on a Saturday, Sunday, or legal holiday, such filing should occur on the preceding business day. All documents are to be filed with the Agency in ***single-sided and in triplicate***.

LETTER OF INTENT: Applications shall be commenced by the filing of a Letter of Intent. The Letter of Intent must be filed with the Agency between the first day and the tenth day of the month prior to the beginning of the review cycle in which the application is to be considered. This allowable filing period is inclusive of both the first day and the tenth day of the month involved. The Letter of Intent must be filed in the form and format as set forth in the application packet.

Any Letter of Intent that fails to include all information requested in the Letter of Intent form, or is not timely filed, will be deemed void, and the applicant will be notified in writing. The Letter of Intent may be refiled but, if refiled, is subject to the same requirements as set out above.

PUBLICATION OF INTENT: Simultaneously with the filing of the Letter of Intent, the Publication of Intent should be published for one day in a newspaper of general circulation in the proposed service area of the project. The Publication of Intent must be in the form and format as set forth in the application packet. The Publication of Intent should be placed in the Legal Section in a space no smaller than four (4) column inches. Publication must occur between the first day and the tenth day of the month, inclusive.

1. A "newspaper of general circulation" means a publication regularly issued at least as frequently as once a week, having a second-class mailing privilege, includes a Legal Notice Section, being not fewer than four (4) pages, published continuously during the immediately preceding one-year period, which is published for the dissemination of news of general interest, and is circulated generally in the county in which it is published and in which notice is given.
2. In any county where a "newspaper of general circulation" does not exist, the Agency's Executive Director is authorized to determine the appropriate publication to receive any required Letter of Intent. A newspaper which is engaged in the distribution of news of interest to a particular interest group or other limited group of citizens, is not a "newspaper of general circulation."
3. In the case of an application for or by a home care organization, the Letter of Intent must be published in each county in which the agency will be licensed or in a regional newspaper which qualifies as a newspaper of general circulation in each county. In those cases where the Publication of Intent is published in more than one newspaper, the earliest date of publication shall be the date of publication for the purpose of determining simultaneous review deadlines and filing the application.

PROOF OF PUBLICATION: Documentation of publication must be filed with the application form. Please submit proof of publication with the application by attaching either the full page of the newspaper in which the notice appeared, with the ***mast and dateline intact***, or a publication affidavit from the newspaper.

SIMULTANEOUS REVIEW: Those persons desiring a simultaneous review for a Certificate of Need for which a Letter of Intent has been filed should file a Letter of Intent with the Agency and the original applicant (as well as any other applicant filing a simultaneous review), and should publish the Letter of Intent simultaneously in a newspaper of general circulation in the same county as the original applicant. The publication of the Letter of Intent by the applicant seeking simultaneous review must be published within ten (10) days after publication by the original applicant.

1. Only those applications filed in accordance with the rules of the Health Services and Development Agency, and upon consideration of the following factors as compared with the proposed project of the original applicant, may be regarded as applications filing for simultaneous review.

   (A) Similarity of primary service area;

(B) Similarity of location;
(C) Similarity of facilities; and
(D) Similarity of service to be provided.

2. The Executive Director or his/her designee will determine whether applications are to be reviewed simultaneously, pursuant to Agency Rule 0720-3-.03(3).

3. If two (2) or more applications are requesting simultaneous review in accordance with the statute and rules and regulations of the Agency, and one or more of those applications is not deemed complete to enter the review cycle requested, the other applications(s) that is/are deemed complete shall enter the review cycle. The application(s) that is/are not deemed complete to enter the review cycle will not be considered as competing with the applications(s) deemed complete and entering the review cycle.

FILING THE APPLICATION: *All applications*, including applications requesting simultaneous review, must be filed in ***triplicate*** (original and two (2) copies) with the Agency within five (5) days after publication of the Letter of Intent. ***The date of filing is the actual date of receipt at the Agency office.***

Applications should have all pages numbered.

All attachments should be attached to the back of the application, be identified by the applicable item number of the application, and placed in alpha-numeric order consistent with the application form. For example, an Option to Lease a building should be identified as Attachment A.6., and placed before Financial Statements which should be identified as Attachment C. Economic Feasibility.10. The last page of an application should be the completed affidavit.

Failure by the applicant to file an application within five (5) days after publication of the Letter of Intent shall render the Letter of Intent, and hence the application, ***void***.

FILING FEE: The amount of the initial filing fee shall be an amount equal to $2.25 per $1,000 of the estimated project cost involved, but in no case shall the fee be less than $3,000 or more than $45,000. Checks should be made payable to the Health Services and Development Agency.

FILING FEES ARE NON-REFUNDABLE and must be received by the Agency before review of the application will begin.

REVIEW OF APPLICATIONS FOR COMPLETENESS: When the application is received at the Agency office, it will be reviewed for completeness. The application must be consistent with the information given in the Letter of Intent in terms of both project scope and project cost. ***Review for completeness will not begin prior to the receipt of the filing fee.***

1. If the application is deemed complete, the Agency will acknowledge receipt and notify the applicant as to when the review cycle will begin. "Deeming complete" means that all questions in the application have been answered and all appropriate documentation has been submitted in such a manner that the Health Services and Development Agency can understand the intent and supporting factors of the application. Deeming complete shall not be construed as validating the sufficiency of the information provided for the purposes of addressing the criteria under the applicable statutes, the Rules of the Health Services and Development Agency, or the standards set forth in the State Health Plan/Guidelines for Growth.

2. If the application is incomplete, requests by Agency staff for supplemental information must be completed by the applicant within sixty (60) days of the written request. Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days which is allowed by the statute. If the requested information is submitted within sixty (60) days of the request, but

not by the date specified in the staff's letter, the application is not void, but will enter the ***next*** review cycle. If an application is not deemed complete within sixty (60) days after the written notification is given by the Agency staff that the application is deemed incomplete, the application shall be deemed void. If the applicant decides to re-submit the application, the applicant shall comply with all procedures as set out by this part and a new filing fee shall accompany the refiled application.

Each supplemental question and its corresponding response shall be typed and submitted on a separate sheet of 8 1/2" x 11" paper, be filed in ***triplicate,*** and include a signed affidavit. All requested supplemental information must be received by the Agency to allow staff sufficient time for review before the beginning of the review cycle in order to enter that review cycle.

3. Applications for a Certificate of Need, including competing applications, will not be considered unless filed with the Agency within such time as to assure such application is deemed complete.

All supplemental information shall be submitted simultaneously and only at the request of staff, with the only exception being letters of support and/or opposition.

The Agency will promptly forward a copy of each complete application to the Department of Health or the Department of Mental Health and Developmental Disabilities for review. The Department reviewing the application may contact the applicant to request additional information regarding the application. The applicant should respond to any reasonable request for additional information promptly.

AMENDMENTS OR CHANGES IN AN APPLICATION: An application for a Certificate of Need which has been deemed complete ***CANNOT*** be amended in a substantive way by the applicant during the review cycle. Clerical errors resulting in no substantive change may be corrected.

* **WITHDRAWAL OF APPLICATIONS**: The applicant may withdraw an application at any time by providing written notification to the Agency.

* **TIMETABLE FOR CERTIFICATE OF NEED EXPIRATION**: The Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; *however*, the Agency may extend a Certificate of Need for a reasonable period upon application and good cause shown, accompanied by a non-refundable filing fee, as prescribed by Rules. An extension cannot be issued to any applicant unless substantial progress has been demonstrated. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

* **For further information concerning the Certificate of Need process, please call the offices of the Health Services and Development Agency at 615/741-2364.**

* **For information concerning the Joint Annual Reports of Hospitals, Nursing Homes, Home Care Organizations, or Ambulatory Surgical Treatment Centers, call the Tennessee Department of Health, Office of Health Statistics and Research at 615/741-1954**

* **For information concerning Guidelines for Growth call the Health Services and Development Agency at 615/741-2364. For information concerning Picture of the Present call the Department of Health, Office of Health Statistics at 615/741-9395.**

* **For information concerning mental health and developmental disabilities applications call the Tennessee Department of Mental Health and Developmental Disabilities, Office of Policy and Planning at 615/532-6500.**

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A"*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

For Section A, Item 4, *Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

1 ***Name of Facility, Agency, or Institution***

Name Life House, LLC.

Street or Route 570 State St County Putnam

City Cookeville State Tn Zip Code 38501

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2 ***Contact Person Available for Responses to Questions***

Name Connie Mitchell Title Director/President

Company Name Life House, LLC. Email address cjmitchell0347@gmail.com

Street or Route 570 State ST City Cookeville State Tn Zip Code 38501

Association with Owner same Phone Number 931-881-6417 Fax Number 931-933-7668

3 ***Owner of the Facility, Agency or Institution***

Name Life House, LLC Phone Number 931-881-6417

Street or Route 570 State St County Putnam

City Cookeville State Tn Zip Code 38501

4 ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or	
B. Partnership		G. Political Subdivision)	
C. Limited Partnership		H. Joint Venture	
D. Corporation (For Profit)		I. Limited Liability Company	x
E. Corporation (Not-for-Profit)		Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

Name

NA _____ _____

Street or Route County

_____ _____ _____

City State Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	___	D.	Option to Lease	_____
B.	Option to Purchase	_____	E.	Other (Specify) Purchase contract delayed closing with lease until closing.	x
C.	Lease of 5 Years	x			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)_____	_____	I.	Nursing Home	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____	J.	Outpatient Diagnostic Center	_____
			K.	Recuperation Center	_____
C.	ASTC, Single Specialty	_____	L.	Rehabilitation Facility	_____
D.	Home Health Agency	_____	M.	Residential Hospice	x
E.	Hospice	_____	N.	Non-Residential Methadone Facility	_____
F.	Mental Health Hospital	___			
G.	Mental Health Residential Treatment Facility	_____	O.	Birthing Center	_____
			P.	Other Outpatient Facility (Specify)_____	_____
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)	_____	Q.	Other (Specify) _____	_____

8. **Purpose of Review** ***(Check) as appropriate--more than one response may apply)***

A.	New Institution	x	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	
B.	Replacement/Existing Facility	_____			
C.	Modification/Existing Facility	_____			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) residential hospice	x	H.	Change of Location	_____
			I.	Other (Specify)_____	_____
E.	Discontinuance of OB Services	___			
F.	Acquisition of Equipment	_____			

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
	Swing Beds					
S.	Mental Health Residential Treatment					
T.	Residential Hospice				10	10
U.	**TOTAL**				10	10
	*CON-Beds approved but not yet in service					

10. **Medicare Provider Number** Will apply for number

Certification Type Residential Hospice

11. **Medicaid Provider Number** Will apply for number

Certification Type Residential Hospice

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid? yes**

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

***Response**: Applicant will contact AmeriChoice, AmeriGroup and Tenncare Select as they are the only MCOs in the proposed service area.*

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Description
This application is to initiate a ten bed residential hospice serving Putnam and eight surrounding counties including Clay, DeKalb, Jackson, Macon, Overton, Pickett, Smith and White counties.

Ownership Structure
Life House, LLC will maintain and be responsible for the management and day to day operation of the facility. Providing administration, staffing and financial support. Jack and Connie Mitchell own the facility. Life House, LLC has a purchase agreement with a five year delayed closing. Life House, LLC will lease prior to closing with them on the facility.

Service Area
The proposed service area includes Putnam and eight surrounding counties of Clay, DeKalb, Jackson, Macon, Overton, Pickett, Smith and White, all within a 50 mile radius of the facility. The population of the service area is estimated to be 215317 in the year 2017. The demographics of this area are reviewed in more detail in the need section of this application.

Existing Resources
There are no residential hospices serving the proposed service area. There are four residential hospice facilities located in Crossville, Nashville and Knoxville which are all over 70-100 miles for the proposed residents and their families. Crossville, being the nearest, reflected no patients from this nine county service area since it opened in 2010.

Need
The nine county service area is projected to have a population of 215317 in 2017. Patients and their families must travel to Nashville, Crossville or Knoxville to access residential hospice services. Because of the distance and the expense, many of the patients from this eight county service are not able to utilize these facilities. The residential hospice bed need formula projects a need of 11 beds in 2017.

Project Cost/Funding
For certificate of need purposes the projected cost is $600000. The facility is an existing residence that has been utilized for a group home for adolescence in the past but most recently a private residence for the owners and their elderly parents. The facility is handicapped ready and has been brought up to hospice specifications. The facility cost of $450000 is under contract for 5 years. The $150000 for the upgrades has been the capital from the Gerharts and the Mitchells to fund the project. Additional operating capital has been raised through a sale of stock.

Financial Feasibility
Through the sale of stock and investment by the corporate investors we have the funds to open and staff the facility.The project is expected to have a positive operating income the first year of operation. The capital expenses for facility improvements have been completed prior to leasing the facility. We have marketing efforts in place that indicate 50% occupancy during our first full year and significant growth in the second to near capacity.

Staffing
The initial proposed staffing will consist of 8.65 FTEs. The clinical staff will consist of FTEs of 3.15 registered nurse, 4.0 aides, .25 social worker, and .25 medical director. The administrator .50 FTEs and clerical staff .50 FTEs.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response

The facility, which contains 4450 square feet, is a group home that has been modified for a residential hospice. It has ten private patient rooms with numerous family quiet areas. The facility has a home like setting with support space consisting of a living room, dining room, quiet meditation areas, large outdoor patio with flowers and bird feeders, a consultation room, nurses' station, medical supply and storage rooms. See attachment B Project Description, IIA Floor Plan

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response

This application is to establish a new ten bed residential hospice facility.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
					4450		4450	600000		600000
B. Unit/Depart. GSF Sub-Total					4450		4450			
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF					4450		4450	$134.83		$134.83

As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. **Residential Hospice**
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

Response

The nine county service area is projected to have a population of 215398 in 2017. The Residential Hospice Need Formula estimates there is a need for 8 beds in this nine county service area. The residential hospice bed need formula uses an assumption (item b) that other non-cancer hospice users are 15% of the total patients. In 2011 the hospices in Tennessee reported 55.9% of the residential hospice users were non-cancer patients. By adjustment of the bed need formula to reflect this high actual number of non-cancer patients, the bed need in the service area increases from 8 to 10.85 or 11 beds.

The patients and their families must travel to Crossville, Knoxville or Nashville to access residential hospice services. Because of the distance, the residents of these counties are not utilizing residential hospice services. The residential hospices in Nashville, Knoxville and even Crossville have reported no admissions from the residents of this nine county area in the 2011 Joint Annual Reports.

Putnam County continues to be rated one of America's Most Affordable communities and has been rated as the Most Affordable community a number of times by the national conductor of the survey, the American Chamber of Commerce Researcher's Association. Cookeville is one of the best retirement communities, according to The Rating Guide to Life in America's Small Cities, and has also been rated one of the best retirement communities by Rand McNally's Places Rated Retirement Guide. A recent article by *Where to Retire Magazine* also named Cookeville as one of the top locations to retire. Our over 55 population in the nine counties is growing, according to the department of health projections. As these retirees join our population they leave their family and support systems behind for their retirement. When sickness or injury occurs, the spouse is the only caregiver. Often the spouse is

unable to provide the required care for the patients to remain in their home. At the present time, the only options are to either admit the patient to a nursing home facility or a hospital or for the patient to relocate closer to extended family. With a resident hospice in the service area, those in the community with a terminal diagnosis would be allowed to spend their final days in a homelike setting in relative comfort. The physical and emotional burden would be lessened for the patient, the caregiver and other family members. All members of the service area with terminal illnesses would have access to high quality residential hospice services.

D. Describe the need to change location or replace an existing faciility.

Response : Not applicable

E Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. **For fixed-site major medical equipment (not replacing existing equipment):**

a Describe the new equipment, including:

1 Total cost ;(As defined by Agency Rule).

2 Expected useful life;

3 List of clinical applications to be provided; and

4 Documentation of FDA approval.

Response: Not applicable

b Provide current and proposed schedules of operations.

Response: not applicable

2 **For mobile major medical equipment:**

a List all sites that will be served;

b Provide current and/or proposed schedule of operations;

c Provide the lease or contract cost.

d Provide the fair market value of the equipment; and

e List the owner for the equipment.

Response: not applicable

3 **Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.**

Response: not applicable

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1 **Size of site (*in acres*);**

2 **Location of structure on the site; and**

3 **Location of the proposed construction.**

4 **Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response: attachment B Project Description, III A Plot Plan

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility ofthe proposed site to patients/clients.

Response: Cats, the Cookeville bus system, runs throughout Putnam county and stops on Willow avenue which is within a few blocks of Life House. Upper Cumberland, also, has a U-cart system that is available throughout our nine counties for area residents. The facility is located only one mile from our major east/west highway I-40. The north/south highways 111 and 136 service the area east of Putnam county and highways 135 and 56 service our area west of Putnam county.

V. For a home health agency or hospice, identify:

Existing service area by County;Proposed service area by County;A parent or primary service provider;Existing branches; andProposed branches.

Response: Our proposed service area is the counties of Clay, DeKalb, Jackson, Macon, Overton, Pickett, Putnam, Smith and White.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. **Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**

   a. **Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.**

Response: The residential Hospice Guidelines are applicable to this application.

b. **Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)**

Response: Not applicable

2. **Describe the relationship of this project to the applicant facility's long-range development plans, if any.**

Response: The applicant does not maintain a long term facility plan.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response: The proposed service area includes nine counties with an estimated 2012 population of 206685. Putnam and the eight contiguous counties which include: Clay, DeKalb, Jackson, Macon, Overton, Pickett, Smith, and White. There are no residential hospice facilities in the service area. See Attachment C Criteria Need, 3 Service Area Map.

4. A. Describe the demographics of the population to be served by this proposal.

Response: The size of the population of the proposed service area is large enough to support this proposed residential hospice. The Tennessee Department of Health indicates the nine county service area will have a population of 215317 in 2017. The 2010 Census report shows the proposed service area to be 2815 square miles. This demographically is an extended Micropolitan area with Putnam, Jackson and Overton counties as the core. The six surrounding rural counties of Clay, DeKalb, Macon, Pickett, Smith, and White, outside any designated statistical area, are included in order to provide core services. Residential hospice services would, otherwise, be unavailable to these residents.

Table 1
Demographics – Putnam County

	Putnam County	State of Tennessee
Population 2010	72321	6,346,105
Population 2010 over 55	26.2	9.4
% of growth 2000-2010	16.2	25.1
Per capita income 2010	$22860	$19393
Persons per square mile 2010	180.3	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 2
Demographics – Clay County

	Clay County	State of Tennessee
Population 2010	7861	6,346,105
Population 2010 over 55 %	35%	9.4%
% of growth 2000-2010	-1.0%	25.1%
Per capita income 2010	18146	$19393
Persons per square mile 2010	33.2	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 3
Demographics – DeKalb County

	DeKalb County	State of Tennessee
Population 2010	18723	6,346,105
Population 2010 over 55 %	29.5%	9.4%
% of growth 2000-2010	8.8%	25.1%
Per capita income 2010	20051	$19393
Persons per square mile 2010	61.5	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 4
Demographics – Jackson County

	Jackson County	State of Tennessee
Population 2010	11638	6,346,105
Population 2010 over 55 %	33.0%	9.4%
% of growth 2000-2010	-1.0%	25.1%
Per capita income 2010	25332	$19393
Persons per square mile 2010	37.7	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 5
Demographics – Macon County

	Macon County	State of Tennessee
Population 2010	22248	6,346,105
Population 2010 over 55 %	24.8%	9.4%
% of growth 2000-2010	8.2%	25.1%
Per capita income 2010	24937	$19393
Persons per square mile 2010	72.4	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 6
Demographics – Overton County

	Overton County	State of Tennessee
Population 2010	22083	6,346,105
Population 2010 over 55 %	25.0%	9.4%
% of growth 2000-2010	4.7%	25.1%
Per capita income 2010	18393	$19393
Persons per square mile 2010	50.9	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 7
Demographics – Pickett County

	Pickett County	State of Tennessee
Population 2010	5077	6,346,105
Population 2010 over 55 %	22.9%	9.4%
% of growth 2000-2010	-3.3%	25.1%
Per capita income 2010	$22411	$19393
Persons per square mile 2010	31.2	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 8
Demographics – Smith County

	Smith County	State of Tennessee
Population 2010	19166	6,346,105
Population 2010 over 55 %	26.6%	9.4%
% of growth 2000-2010	8.4%	25.1%
Per capita income 2010	27849	$19393
Persons per square mile 2010	61.0	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

Table 9
Demographics – White County

	White County	State of Tennessee
Population 2010	25841	6,346,105
Population 2010 over 55 %	31.5%	9.4%
% of growth 2000-2010	10.1%	25.1%
Per capita income 2010	22313	$19393
Persons per square mile 2010	68.6	138.0

Sources: State of Tennessee Population Projects, Tennessee Health Department, Us Census Bureau

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: In 2017, 528 residents of this nine county area are expected to die from cancer. Convenient access to a residential hospice program is an essential element of a comprehensive cancer treatment program. Currently the residents of the nine-county service area do not have convenient access to residential hospice services. The implementation of this proposed 10 bed hospice will significantly increase the access to this much needed service to 215317 residents of our service area.

Table 10
Cancer Death Data

County	2010 Cancer Deaths	2010 Population	Cancer Deaths/1000 %	2017 Projected Population	2017 Projected Cancer Deaths
Clay	24	7861	3.12	8318	26
DeKalb	53	18723	2.83	20161	57
Jackson	29	11638	2.51	11797	30
Macon	59	22248	2.66	24408	65
Overton	63	22083	2.85	21832	63
Pickett	13	5077	2.60	5221	13
Putnam	139	72321	1.92	76042	146
Smith	56	19166	2.92	21156	62
White	57	25841	2.21	26382	58
Total	493	204958		215317	528

The Tennessee Residential Hospice Bed Need Formula reflects the following need based on the preceding cancer statistics.

Table 11

Bed Need

Non-cancer hospice usage	**2010 15%**	**2010 55.6%**	**2017 15%**	***2017 55.6%***
Cancer Deaths	493	493	528	***528***
Patient Hospice utilization 40%	198	198	212	***212***
Other users 15 and 55.6%	30	111	32	***119***
Total Hospice Users	228	309	244	***331***
Total hospice days = Users x average stay 45 days	10260	13905	10980	***14895***
Average daily hospice census = Total days divided by 365	29	39	31	***41***
20% average daily census (adc)	5.8 = 6	7.8 = 8	6.2=7	***8.2 = 9***
Bed need = adc divided by .85 occupancy	7.06	9.41	7.29	***10.59***
Bed Need	8	10	8	***11***

5. **Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

Response: Not applicable. There are no existing nor approved but unimplemented CONs for residential hospice in the proposed service area.

6. **Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

Response: Since this application is for a new facility, historical utilization is not available. The residential hospice bed need formula, adjusted to reflect 55.9 percent of the patients are non-cancer patients, was used to determine the number of residential hospice patient days in 2013. Using this formula and a projected 50% occupancy, the nine-county service area would be expected to generate 1500 residential hospice patient days in 2013. Because 2014 is the first full year of operation, and the affect of the ramp up, the applicant expects to provide 3000 patient days of care. Subsequent years would be expected to be 3102 based on the hospice need formula.

C. ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

    - **A. All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**

Response: Excluding the filing fee, the total project cost is estimated to be $597000. The filing fee was determined to be $3000 and is shown on line E of the Project Costs Chart.

- **B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.**

Response: The building is leased by Life House, LLC for $3750 per month for five years. The total of the lease payments is $225000. The market value of the property is $509000 with required improvements in attachment C Economic feasibility, D1 Architect letter, thus the market value, which is greater, was used to determine the project cost. See attachment C Economic Feasibility, B1 Residential Appraisal

- **C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

Response: The cost of the equipment was estimated to be $15,000 and includes these items when appropriate. None of this equipment requires a service agreement.

- **D. For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response: Attached is a letter from Michael Brady, Inc Architects stating the project remodel cost was $109,000. Attachment C Economic Feasibility, D-1 Architect Letter.

PROJECT COSTS CHART

A.		**Construction and equipment acquired by purchase:**	
	1.	**Architectural and Engineering Fees**	5000
	2.	**Legal, Administrative (Excluding CON Filing Fee), Consultant Fees**	
	3.	**Acquisition of Site and Building**	
	4.	**Preparation of Site (parking)**	5000
	5.	**Construction Costs (Completed remodel)**	90000
	6.	**Contingency Fund**	18000
	7.	**Fixed Equipment** (Not included in Construction Contract)	14000
	8.	**Moveable Equipment** (List all equipment over $50,000)	15000
	9.	**Other (Specify)** _____	
B.		**Acquisition by gift, donation, or lease:**	
	1.	**Facility (inclusive of building and land)**	450000
	2.	**Building only**	
	3.	**Land only**	
	4.	**Equipment (Specify)**_____	
	5.	**Other (Specify)** _____	
C.		**Financing Costs and Fees:**	
	1.	**Interim Financing**	
	2.	**Underwriting Costs**	
	3.	**Reserve for One Year's Debt Service**	
	4.	**Other (Specify)** _____	
D.		**Estimated Project Cost (A+B+C)**	597000
E.		**CON Filing Fee**	3000
F.		**Total Estimated Project Cost (D+E) TOTAL**	$600000

2. **Identify the funding sources for this project.**

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

__ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

__ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**

__ **D. Grants--Notification of intent form for grant application or notice of grant award; or**

x **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

_ **F. Other—Identify and document funding from all other sources.**

Response: The building is under lease contract for $3750.00 per month, with all the improvements completed, with the lease to begin on 02/01/2013. See attachments C Economic Feasibility, 2F-1 Lease.

The only other capital needed is for moveable equipment. The capital need is estimated to be $33,000. A letter from Jack Mitchell, CFO states the funds are available and will be used for this purpose. See attachment C Economic Feasibility, 2F-2 Letter.

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

Response: Since 2007, four applications have been approved for residential hospice services. The cost of this project appears to be well in line with these projects. This project required very little upgrading because of the prior usage, compared to the cost of new construction in a more institutional setting. The costs of the other hospices are presented in the following table:

Table 12

Project Costs

Facility	CNO #	Projected Cost	Beds	Cost per bed
Life house, LLC		$600,000	10	$60,000
Hospice of Cumberland County	CNO709-085	$742,010	6	$123668
Baptist Memorial	CNO709-069	$10,254,656	24	$427,277
Caris House	CNO703-023	$5,288,573	18	$293,810
Alliance Health	CNO709-067	$9,179,386	30	$305,980

4. **Complete Historical and Projected Data Charts on the following two pages--*Do not modify the Charts provided or submit Chart substitutions!* Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections** for the *Proposal Only* **(*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

Response: Since the application is for a new residential hospice facility, historical data is not available.

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

Response: The gross charge, average deduction from operating revenue and the average net charge per patient day is as follows:

Table 13

Average Net Charges

	Year 1	**Year 2**
Average Gross Charge	$418.70	$418.70
Average Deduction	7.99	$7.72
Average Net Charge	$410.71	$410.98

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

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	Year____	Year___	Year_____
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____	_____
Gross Operating Revenue	$_____	$_____	$_____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE	$_____	$_____	$_____
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Other Expenses (Specify) _____	_____	_____	_____
Total Operating Expenses	$_____	$_____	$_____
E. Other Revenue (Expenses) – Net (Specify)	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	$_____	$_____	$_____
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$_____
2. Interest	_____	_____	_____
Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$_____	$_____	$_____

Response: Not Applicable

PROJECTED DATA CHARTS 2013 JAN 8 AM 11 51

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

		Year 2013	Year 2014
A.	Utilization Data (Specify unit of measure)	1500	3000
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 628050	$ 1256100
2.	Outpatient Services		
3.	Emergency Services		
4.	Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$ 628050**	**$ 1256100**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$	$
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 11984**	**$ 23160**
NET OPERATING REVENUE		**$ 616066**	**$ 1232940**
D.	Operating Expenses		
1.	Salaries and Wages	$ 310897	$ 379769
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	40000	75000
4.	Taxes	0	0
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list) _____	$ 110400	143382
	Total Operating Expenses	**$ 541297**	**$ 693151**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 74769**	**$ 539789**
F.	Capital Expenditures		
1.	Retirement of Principal	$	$ 250000
2.	Interest		
	Total Capital Expenditures	$	$
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 74769**	**$ 289789**

Other expenses are:

Table 14
Other expenses

	Year 1	Year 2
Pharmacy, therapy, lab	$ 74800	$104682
Insurance	4000	4000
Utilities	8600	9600
General/office supplies	7000	8600
Contract laundry	2500	3000
Miscellaneous	13500	13500
Total	$110400	$143382

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: Since this application is for a new facility, current charges have not been established. First year gross revenue projections are expected to be $628050 or $418.70 per patient day.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Table 15

Average Daily Charge

Facility	Average Charge
Life House, LLC	418.70
Hospice of Cumberland County	552.00
Wellmont	584.00
Alive	658.00

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The program is projected to have an average census of 8.2 patients during the second year of operation. Utilization of 50% is sufficient to breakeven in our first year. This utilization rate of 82% will generate a significant positive cash flow our second year and allow for any required capital expenditures and/or reserves.

8. Discuss how financial viability will be ensured within two years; and demonstrate the viability of sufficient cash flow until financial viability is achieved.

Response: We have numerous investors ready to purchase shares of corporation, once the CON is approved, which will give us ample operating capital if required. As shown on the projected data chart, the project is showing a positive net operating income in the first year of operation. The second year shows a significantly higher positive net operating income with less than complete utilization.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: The proposed facility will be a provider for both Medicare and TennCare/Medicaid providers. During the first year of operation, approximately 95% of our gross revenue is expected to be from these programs. Gross revenue from the Medicare program is expected to be $564617 (89.9%), and $32031 (5.1%) from TennCare/Medicaid.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response: See attached balance sheets from Cleston Daniels, CPA. AttachmentC, Economic Feasiblity-10 CPA Data.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: Since the building has been completed and furnished, no more cost effective alternative hospice solutions are available.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: This facility is remodeled to architect specifications and is completed, furnished and ready for patient occupancy, at a cost significantly less than the new construction residential hospices recently approved.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

Response: The applicant will be working with all local health care providers including Cookeville Regional Medical Center, Cookeville Regional Cancer Center, Livingston Regional Hospital, area home health agencies and hospice care givers.

2. **Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

Response: The implementation of this proposed service will have a positive effect on the health care system by significantly increasing the accessibility to the residential hospice services to the residents of the nine-county service district. Since residential hospice is not available in the service area, duplication or competition with existing programs will not occur as a result of the initiation of this proposed service.

3. **Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.**

Response: The facility is expected to be staffed with a total of 8.65 FTE employees. The following table summarizes the expected staffing and wages. The wages are compared to the State of Tennessee Department of Labor and Workforce Development.

Table 16

Hourly Wages Comparisons

POSITION	FTEs	HOURLY WAGE Expected	HOURLY WAGE Median
Registered Nurse	3.15	20.00	22.77
Hospice Aide (CNT)	4.0	12.00	9.96
Social Worker	.25	15.00	20.00

Tn. Department of Labor 2011 Statistics

4. **Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.**

Response: The proposed staffing is 8.65 FTEs. The applicant does not anticipate a problem filling these positions.

Table 17
Expected Staffing

POSITION	FTEs
Chief Executive Officer-Administrator	.50
Medical Director	.25
Social Worker	.25
Registered Nurse	3.15
Aides	4.00
Clerks/ receptionist	.25
Billing/bookkeeping	.25
Total	8.65

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.***

Response: The applicant is very familiar with the licensing requirements. The proposed facility will comply with all licensing regulations.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).**

Response: The applicant will be requesting an affiliation with Tennessee Tech University to serve as a training site.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

Response: The applicant understands the applicable licensure requirements of the Department of Health and all applicable Medicare requirements.

(b) **Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.**

Licensure: The facility will be licensed by the Tennessee Department of Health.

Accreditation: The facility will be accredited by the Community Health Accreditation Program (Chaps).

(c) **If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.**

Response: Not applicable. The application is for a new facility.

(d) **For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.**

Response: Not applicable. The application is for a new facility.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response: Not applicable

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

Response: Not applicable.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Response: The applicant will provide the Tennessee Health Services and Development Agency with information concerning the number of patients treated, types of procedures performed and any other data, as required.

PROOF OF PUBLICATION

2013 JAN 8 AM 11 52

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: Attachment Proof of Publication is the full page from the newspaper in which the notice of intent was published.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

Response: The chart is complete.

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Response: Not applicable. An extended schedule is not being requested.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

April 1, 2013 is the projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): _____

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	**DAYS REQUIRED**	**Anticipated Date (MONTH/YEAR)**
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy		
10. *Issuance of license		04/2013
11. *Initiation of service		04/2013
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Attachment
Section A, Applicant Profile, Item 3
Life House, LLC Documents

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

LIFE HOUSE, LLC
570 STATE ST
COOKEVILLE, TN 38501-3718

July 2, 2012

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 656664 Status: Active
Filing Type: Limited Liability Company - Domestic

Document Receipt

Receipt # : 786281 Filing Fee: $20.00

Payment-Account - C J MITCHELL, COOKEVILLE, TN $20.00

Amendment Type: Articles of Amendment Image # : 7070-2473
Filed Date: 07/02/2012 1:53 PM

This will acknowledge the filing of the attached articles of amendment with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above.

You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee.

Tre Hargett
Secretary of State

Processed By: Annette Boyd

Field Name	Changed From	Changed To
Filing Name	AUTHOR DIRECT MARKETING, LLC	LIFE HOUSE, LLC

Attachment
Section A, Applicant Profile, Item 4
Ownership Structure

President(Chair) -	Constance Mitchell
Vice President -	Richard Gerhart
Secretary -	Sylvia Gerhart]
Treasurer -	Jack Mitchell

The officers so elected, each being present, accepted his or her office(s).

8 Issuance of Stock.

The Chairman presented a number of stock subscriptions submitted to the Board relating to the issuance and sale of shares of the Corporation to the following individuals for the consideration, and in the amounts, as indicated below:

NAME	NO. SHARES	CONSIDERATION
Constance Mitchell	25001	$25001
Jack Mitchell	24999	$24999
Sylvia Gerhart	25001	$25001
Richard Gerhart	24999	$24999

On motion duly made, seconded and unanimously carried, the following preamble and resolutions were adopted:

WHEREAS, this Limited Liability Corporation is authorized to issue an aggregate of 100000 shares of its capital stock;

NOW THEREFORE, be it

RESOLVED, that the President, or the Vice President, or the Secretary, or the Treasurer, be and they hereby are authorized and directed to sell and issue shares of stock of this Corporation to the persons and in the amounts and for the consideration stated in these minutes.

RESOLVED, that all such shares of stock shall be evidenced by a certificate or certificates which shall have placed prominently thereon legends with respect to Section 1244 stock and that such stock is not a registered security under state or federal securities laws.

MINUTES OF ORGANIZATIONAL MEETING
OF THE BOARD OF DIRECTORS OF
Life House, LLC

1 Time and Place.

The Board of Directors of Life House, LLC held its organizational meeting on 11/15/2012 at 570 State St, Cookeville, Tn 38501 at 2:00 PM.

2 Attendance.

The following directors of the Corporation were present:
Constance Mitchell, 570 State St, Cookeville, Tn 38501
Jack Mitchell, 570 State St, Cookeville, Tn 38501
Sylvia Gerhart, 2010 Byrdstown, Livingston, Tn 38570
Richard Gerhart 2010 Byrdstown, Livingston, Tn 38570

No directors were absent.

3 Presiding Officers and Quorum.

Constance Mitchell called the meeting to order and acted as Chairman thereof, and Sylvia Gerhart acted as secretary of the meeting. The Chairman announced that a quorum of the directors was present, and that the meeting, having been duly convened, was ready to proceed with its business.

4 Articles of Incorporation.

The Chairman stated that the original Articles of Incorporation had been filed in the Secretary of the state of Tennessee on 04/15/2012. The Chairman presented to the meeting a certified copy of said Articles of Incorporation, showing filing as stated, and the Secretary was directed to insert said copy in the minute book of the LLC.

5 Agreement of Operation.

The matter of the adoption of Agreement of Operation for the regulation of the LLC was next considered. The Chairman presented to the meeting an Agreement of Operation and recommended that the same be adopted as the Agreement of Operation for Life House, LLC. On motion duly made and unanimously carried, the following resolutions were adopted:

WHEREAS, Agreement of Operation for the regulation of the affairs of this LLC have not yet been adopted; and

Attachment
Section A, Applicant Profile, Item 5
Management Resume

Sylvia A. Gerhart

OBJECTIVE

Opportunity of challenge and to contribute which will draw upon and add to my life experiences.

EXPERIENCED IN THE FOLLOWING AREAS

Nutritional Counseling
Real Estate Management
Family practice office/phone nurse
Urban Ministry
Congregational nursing
Youth
Parenting/Ministry

ACHIEVEMENTS

***Parented eighteen young men of at-risk origin to American normalcy, mentality and hope.**
***Impacted the lives of over 1500 persons-in-crisis, supporting, encouraging and facilitating their movement from crisis to normality. Developed a city-wide information sharing network for local and national help agencies present to increase efficiency of all agencies.**
***Was member of first graduating class of congregational nurses from Marion General Hospital and facilitated that program in the inner city.**
***Purchased and renovated over sixty living units in inner city slum areas to change neighborhoods and give new life and hope to residents there.**
***Worked in family practice office as medical manager and phone nurse.**
***Functioned as program nurse for hospital based weight management program in medical and sales promotion.**

EMPLOYMENT HISTORY

HEPHZIBAH CHILDREN'S HOME, MACON, GEORGIA: **Parented a total of eighteen at-risk boys, ages twelve to nineteen, 24 hours a day six days per week, living on site with them, tutoring, traveling, camping, sports, etc. Campus nurse. 2001- 2003**

URBAN MINISTRY, MARION, INDIANA: **Lived and worked in inner-city plagued by crime, substance abuse, unemployment and poverty. Opened a thirty bed rescue center providing counsel, clothes, food , and work resources to the crisis clients there. Participated in jail visitation and ministry, and owner/ operated a fast food restaurant, purchased and helped renovate over sixty real estate units to provide work opportunities and housing for the urban disenfranchised. Started a congregational nurse program in this same area of the inner city.1996-2001.**

SAMUEL E. TONEY, MD, FAMILY PRACTICE, MARION, INDIANA: **Medical manager and phone nurse for 4,500 patient family practice office.1993-1996.**

SPARROW HOSPITAL WEIGHT MANAGEMENT CENTER, LANSING, MICHIGAN: **Program nurse for hospital based, physician managed weight management center. Performed physicals, EKGs ,counseled patients and assisted in explaining and selling the program to patients diagnosed with morbid obesity. 1989-1992**

GERHART PHARMACY, DOWNING TOWN, PENNSYLVANIA: **Owned and managed two pharmacy chain business, which serviced nursing homes and residential schools as well as retail trade. 1982-1984.**

EDUCATION

Nursing Diploma, Presbyterian Hospital, Philadelphia, Pennsylvania.

Richard T. Gerhart

OBJECTIVE

An executive position in an operations related area that would challenge an individual that has manufacturing management background and creative thinking ability who can be of help in the following areas:

- Identify problems as they related to labor, materials, and equipment to develope innovative solutions.
- Organizing, training and leading personnel to effect greater productivity.
- Consulting with senior fiscal management to review financial results and recommend alternatives to maximize profitability.

EXPERIENCED IN THE FOLLOWING AREAS

Consulting	Facility Management	Project Coordination
Fiscal Management	Personnel Recruitment	Personnel Training
Policy Development	Quality Control	Pharmaceutical Manufacturing
Off-Shore Operations	Labor Negotiation	Nutritionals Manufacturing

ACHIEVEMENTS

- Orchestrated the many in-company and outside players essential to produce an off-shore production facility on schedule within budget, which made the corporate goal of reducing high level tax exposure liability.
- Analyzed correctly the factors contributing to the production facility failures symptomatic of poor quality, low employee morale and budget failures which then enabled a successful plant turn around.
- Established the goals, their respective priorities, their prerequisites to each goal and a workable time-table to successfully turn around in fifteen months an ineffective management team producing a poor quality product on a run away budget.
- Served as consultant to top management and plant management to investigate, recommend and then implement measures to reverse a potential plant closing by the Federal Food and Drug Administration.
- Increased the plant capacity of the facility from eight points-market share to twenty-one points-market and eliminated the need to invest $80,000,000 in new facility construction at an actual cost less than $6,000,000.
- Led the production facility in writing, acting and producing a quality inter-division video communication to provide assurance and instill confidence to motivate the sales force which in turn provided incentive in Operations Division to increase productivity.
- Reversed a Director-Managerial level atmosphere characterized by mutual disrespect, incompetency, apathy, in-fighting and distrust to build a team respected internally and externally which excelled at their assignments and felt good about their accomplishments.
- Held the incremental increase in product cost at ten % over a two year period where in exempt staffing increased forty %, plant investment increased eighteen %, and inventory turns increased from nineteen to twenty one turns despite a twenty % increase in components.

EXPERIENCE

WYETH-AYERST LABORATORIES, INC.

PLANT MANAGING DIRECTOR: overall responsibility for three production facilities encompassing over 550,000 square feet of space, and operating budget of $75,000,000 and capitol budget of $10,000,000 annually. 1986-1990

ASSISTANT GENERAL MANAGER: responsible for complete staffing, procedures development, training, and validation of 500 employee plant start-up operation. 1984-1986

ASSISTANT TO VICE-PRESIDENT, MANUFACTURING: developed the conceptual design of a 600,000 sq. ft. $90,000,000 state of art production facility in Puerto Rico. Served as policy writer/auditor and consultant to five manufacturing facilities. 1981-1984

GERHART PHARMACY
Owner of Retail Pharmacy chain: Started new business, expanded by purchase of three stores and addition of a fifth store, servicing nursing homes and residential schools, as well as retail trade. 1972-1984

WYETH LABORATORIES, INC.
MANAGER OF MANUFACTURING: responsibility for manufacturing units producing tablet and capsule granulations, tablet pressing, tablet coating, penicillin oral products, oral-contraceptive products. 1967-1972

SUPERVISOR; supervisory positions in ware-housing, manufacturing, packaging, production control of pharmaceuticals. 1963-1967

EDUCATION

Bachelor of Science, Temple University, 1962
M.A. World Missions & Evangelism, Asbury Seminary 1993

Jack Mitchell

Resume

Jack Mitchell
570 State St, Cookeville, TN 38501
931-284-7227
jwmitchell0944@gmail.com

Professional Summary

I am a dedicated person with a proven track record of success with the ambition, drive and work ethic to be successful in any given environment. I have the people skills to manage others as well as the education and job experience to understand the bottom line needed by successful companies. Although, I have extensive experience as an entrepreneur as well as a corporate management team member, I am always up to the challenge whatever the situation. I am seeking a rewarding position that can utilize my experience and talents while giving the opportunity to develop new skills, as the position may demand.

Work Experience

September 1997 to March 2010
MetLife Auto and Home
Warwick, RI
Regional Market Development Manager

I was responsible for the growth and development of a multi-state region for the company. My duties required the collection of data and using that data to develop on going action plans to hire and train
personnel to profitably meet company goals. During my time with the company I received recognition as
The National Production Leader, as well as numerous awards for management abilities. I retired from the company in 2010.

January 1971 to June 1991
TIS, Inc
Nashville, TN
President/Owner

President and CEO of a multi-million dollar insurance agency. Responsible for overall management of several employees to provide service to clients. Sold agency in 1991.Retired for the first time and immediately enrolled in college for the first time.

March 1967 to December 1970
Shelter Insurance
Columbia, Mo
District Manager

Hired and trained staff for producing product sales in my district. Won several awards for success. Left to start my own agency.

Education

Austin Peay State University
Clarksville, TN
Bachelor of Science 1993
Health Care Administration

Austin Peay State University
Clarksville, TN
Master of Science 1994
Public Health

Tennessee State University
Nashville, TN
PhD ABD.1997
Public Administration

Constance (Connie) Mitchell

570 State St
Cookeville, Tn 38501
Phone: 931-881-6417
E-Mail: cjmitchell0347@gmail.com

Career Focus

Compassionate client focused manager with strong customer satisfaction focus. Goal driven yet team oriented with the ability to organize staff to a common mission. My background in sales, with highly competitive and dynamic organizations, has instilled the need for tact and compromise. My management style is lead with the consent and cooperation of the led.

Summary of Skills

- Business Development
- Strategic planning
- Process development
- Top-rated sales performance
- Strategic event planning
- Trade show management
- Customer targeting
- Client acquisition
- Computer proficient
- Compassionate Client relations
- Sensitive Negotiation skills
- Complex problem resolution
- Needs assessments
- Needs satisfaction
- Conflict resolution

Accomplishments

Management

- Recruited and directed marketing team of 20 direct report agents
- Supervised creation of marketing strategies/plans and ensured operations were within budget constraints and meeting sales goals.
- *Sales and Marketing*
- Met or exceeded all market goals
- Multiple sales leader conference qualifier

- Property Management
- Managed all aspects : procurement, accounting, tenant relations, maintenance, legal matters

Attachment
Section A, Applicant Profile, Item 6
Lease Agreement

Purchase Agreement

Agreement to Purchase

This is a legally binding contract. If you do not understand this contract, please seek legal council.

THIS AGREEMENT entered into on the 6th day of January, 2013 by and between, Life House, LLC, hereinafter referred to as "Buyer", and Jack W. and Constance J. Mitchell, a married couple, hereinafter referred to as "Seller".

1. **PROPERTY PURCHASED**: In consideration of the mutual promises herein contained, the Seller agrees to sell, and the Buyer agrees to buy, in accordance with the terms and conditions of this Agreement, the following described Real Property, Situated in the City of Cookeville, the County of Putnam and the State of Tennessee, and described as follows:
   570 State St., Cookeville, Tn 38501.
   Together with all the improvements thereon, all privileges, appurtenances, easements, and all fixtures presently situated in said building, including, but not by way of limitation: all heating and air conditioning equipment; all electrical, plumbing and bathroom fixtures; venetian blinds; awnings; curtains, draperies, & traverse rods; window & door screens; wall to wall, stair, and similar attached floor covering and carpets; 1 built-in ranges top, 2 built-in ovens, 2 refrigerators, 2 dishwashers, 2 garbage disposals, fireplace gas logs and doors, washing machines; dryer; all affixed or built-in furniture and fixtures; all landscaping, trees and shrubs; all utility/storage buildings or sheds; except:
   Dish tv units and equipment, any fixtures removed as part of the remodel to include but not limited to cabinets, mirrors, shower doors, garage door and other materials as removed.

2. In addition to the above the following shall be included in the sale:
   none
   A. **PRICE AND TERMS**: Buyer hereby agrees to pay for said property the sum of four hundred fifty thousand Dollars ($450,000) payable as follows: $10000.00 "Earnest Money" to apply toward the purchase price to be non-refundable. If buyer defaults in the performance of this contract as hereafter provided, the all capital improvements shall be kept by the seller as damages. $5000 on 1/7/13 and balance by 2/7/13 with investor funds
3. **FINANCING**: Contingent upon the buyer obtaining a satisfactory first mortgage. The Buyer agrees to apply for a mortgage by September 31, 2017.
4. **EVIDENCE OF TITLE**: in the form of a title search and owner's policy of title insurance, will be furnished by Seller, and shall be subject to the approval of the Buyer. A preliminary binder shall be provided to Buyer, for his review and approval, 48 hours prior to closing.
5. **SELLER'S CERTIFICATION**: Seller certifies to Buyer that, to the best of Seller's knowledge (a) there is no termite damage to the REAL ESTATE; (b) the fireplaces, chimneys, electrical, plumbing, heating, air conditioning equipment and systems, and other items included herein will be operational on Possession; (c) the REAL ESTATE is zoned by exception for a ten bed residential hospice; (d) there are no pending orders or ordinances or resolutions that have been enacted authorizing work or improvements for which the REAL ESTATE may be assessed; and (e) no City, County or State orders have been served upon him requiring work to be done or improvements to be made which have not been performed.
6. **INSPECTION**: Seller agrees to give Buyer, and/or his agent, access to property prior to possession to inspect the entire premises. Inspection shall include every room, the roof, plumbing, wiring, structure, foundation and all mechanical components. Should any deficiencies be found, the Seller shall have the option of repairing the deficiency, deducting the cost of the repair from the down payment, or notifying the Buyer that the Seller cannot meet the terms of this contract and refunding the Earnest Money deposited by the Buyer.
7. **CONVEYANCE AND CLOSING**: Closing to be on or before December 31, 2017. Seller shall be responsible for deed(s) preparation; and shall convey marketable title to the REAL ESTATE by deed of general warranty in fee simple absolute at closing.
   Seller shall have the right to remove any and all encumbrances or liens at the Closing out of the Purchase Price. Possession shall be given February 1, 2013. Buyer to lease the property for $3750 per month until closing. See attached lease agreement.

8. **PRORATIONS**: There shall be prorated between Seller and Buyer as of Closing all (a) real estate taxes.
9. **CONDITION OF IMPROVEMENTS**: Seller agrees that on Possession, the REAL ESTATE shall be in the same condition as it is on the date of this Purchase Offer, except for ordinary wear and tear. In case the REAL ESTATE herein referred to is destroyed wholly or partially by fire or other casualty, Buyer shall have the option for 10 days thereafter of proceeding with the terms of this contract, with an agreed adjustment in the sale price, or of terminating this agreement.
10. **DEFAULT**: It is expressly agreed that upon the event of any default or failure on the part of the Buyer, to comply with the terms and conditions of this contract, that Seller agrees to accept the EARNEST MONEY deposit and all capital improvements as full liquidated damages.
11. **SOLE CONTRACT**: The parties agree that this Agreement to Purchase and attached lease agreement constitutes their entire agreement and that no oral or implied agreement exists. Any amendments to this Contract shall be made in writing, signed by all parties and copies shall be attached to all copies of the original Purchase Contract. The terms and conditions of this Contract are to apply to and bind and inure to the benefit of the heirs, executors, administrators, successors, and assigns of the respective parties. All provisions of this contract shall survive the closing. All parties are advised to seek competent advice, unless they fully understand all terms of the contract. Should there be any term or condition in this contract that is not in accord with the applicable legal statutes, either party may void that portion of the contract by having his lawyer furnish a written opinion stating the reason, and citing the proper law or court case.
12. **EXPIRATION**: This offer shall expire unless a copy hereof with Seller's written acceptance is delivered to Buyer or his Agent on or before 12:00 PM on January 6, 2013.
13. **APPROVAL**: The undersigned Buyer(s) has read, fully understands and approves the foregoing offer and acknowledges possession of a signed copy.

Buyer Loft Homes LLC By R Shuman Garland

Date: 1/6/13

ACCEPTANCE

The undersigned Seller(s) has read, fully understands and verifies the above information as being correct and accepts the foregoing offer; agreeing to sell the herein described property on the terms and conditions herein specified and acknowledges receipt of a signed copy.

Seller: Jacob M. Wheeler Seller: Constance Whitesell

Date: 1/6/13

Lease Agreement

COMMERCIAL LEASE AGREEMENT

THIS LEASE (this "Lease") dated this ____6_____ day of January, 2013 BETWEEN:

Jack and Constance Mitchell of 398 Acorn Lane, Gainsboro, Tn
Telephone: 931-881-6417 Fax: _____
(the "Landlord")

OF THE FIRST PART

- AND -

Life House, LLC of Cookeville, Tennessee
Telephone: 931-644-1785 Fax: 931-933-7668
(the "Tenant")

OF THE SECOND PART

N CONSIDERATION OF the Landlord leasing certain premises to the Tenant, the Tenant leasing those premises from the Landlord and the mutual benefits and obligations set forth in this Lease, the receipt and sufficiency of which consideration is hereby acknowledged, the Parties to this Lease (the "Parties") agree as follows:

Definitions

1. When used in this Lease, the following expressions will have the meanings indicated:

a. "Additional Rent" means all amounts payable by the Tenant under this Lease except Base Rent, whether or not specifically designated as Additional Rent elsewhere in this Lease;

b. "Building" means all buildings, improvements, equipment, fixtures, property and facilities from time to time located at 570 State St, Cookeville, Tn 38501, as from time to time altered, expanded or reduced by the Landlord in its sole discretion;

c. "Common Areas and Facilities" mean:

i. those portions of the Building areas, buildings, improvements, facilities, utilities, equipment and installations in or forming part of the Building which from time to time are not designated or intended by the Landlord to be leased to tenants of the Building including, without limitation, exterior weather walls, roofs, entrances and exits, parking areas, driveways, loading docks and area, storage, mechanical and electrical rooms, areas above and below leasable premises and not included within leasable premises, security and alarm equipment, grassed and landscaped areas, retaining walls and maintenance, cleaning and operating equipment serving the Building; and

ii. those lands, areas, buildings, improvements, facilities, utilities, equipment and installations which serve or are for the useful benefit of the Building, the tenants of the Building or the Landlord and those having business with them, whether or not located within, adjacent to or near the Building and which are designated from time to time by the Landlord as part of the Common Areas and Facilities;

d. "Leasable Area" means with respect to any rentable premises, the area expressed in square feet of all floor space including floor space of mezzanines, if any, determined, calculated and certified by the Landlord and measured from the exterior face of all exterior walls, doors and windows, including walls, doors and windows separating the rentable premises from enclosed Common Areas and Facilities, if any, and from the center line of all interior walls separating the rentable premises from adjoining rentable premises. There will be no deduction or exclusion for any space occupied by or used for columns, ducts or other structural elements;

e. "Premises" means the building at 570 State St, Cookeville, Tn 38501.

Intent of Lease

2. It is the intent of this Lease and agreed to by the Parties to this Lease that the lessee(buyer) will rent the premise subject to the attached purchase contract date January 6, 2013 by and between the same parties, hereto attached..

Leased Premises

3. The Landlord agrees to rent to the Tenant the building municipally described as 570 State St, Cookeville, Tn 38501, (the "Premises") . The Premises will be used for only the following permitted use (the "Permitted Use"): Residential Hospice or home for the aged. Neither the Premises nor any part of the Premises will be used at any time during the term of this Lease by Tenant for any purpose other than the Permitted Use.

4. While the Tenant, or an assignee or subtenant approved by the Landlord, is using and occupying the Premises for the Permitted Use and is not in default under the Lease, the Landlord agrees not to Lease space in the Building to any tenant who will be conducting in such premises as its principal business, the services of: Residential Hospice or home for the aged.

5. Subject to the provisions of this Lease, the Tenant is entitled to the use of parking (the 'Parking') on or about the Premises. Only properly insured motor vehicles may be parked in the Tenant's space.

Term

6. The term of the Lease commences at 12:00 noon on February 1, 2013 and ends at 12:00 noon on December 31, 2017.

7. Upon 30 days notice, the Landlord may terminate the tenancy under this Lease if the Tenant has defaulted in the payment of any portion of the Rent when due.

8. Upon 30 days notice, the Landlord may terminate the tenancy under this Lease if the Tenant fails to observe, perform and keep each and every of the covenants, agreements, stipulations, obligations, conditions and other provisions of this Lease to be observed, performed and kept by the Tenant and the Tenant persists in such default beyond the said 30 days notice.

9. Should the Tenant remain in possession of the Premises with the consent of the Landlord after the natural expiration of this Lease, a new tenancy from month to month will be created between the Landlord and the Tenant which will be subject to all the terms and conditions of this Lease but will be terminable upon either party giving one month's notice to the other party.

Rent

10. Subject to the provisions of this Lease, the Tenant will pay a base rent of $3,750.00, payable per month, for the Premises, which includes a monthly charge of $__0_____ for the Parking (collectively the "Base Rent").

11. The Tenant will pay the Base Rent on or before the first of each and every month of the term of this Lease to the Landlord.

12. For any rent review negotiation, the basic rent will be calculated as being the higher of the Base Rent payable immediately before the date of review and the Open Market Rent on the date of review.

Use and Occupation

13. The Tenant will use and occupy the Premises only for the Permitted Use and for no other purpose whatsoever. The Tenant will carry on business under the name of Life House and will not change such name without the prior written consent of the Landlord, such consent not to be unreasonably withheld.

14. The Tenant covenants that the Tenant will carry on and conduct its business from time to time carried on upon the Premises in such manner as to comply with all statutes, bylaws, rules and regulations of any federal, provincial, municipal or other competent authority and will not do anything on or in the Premises in contravention of any of them.

Advance Rent and Security Deposit

15. On execution of this Lease, The Tenant will pay the Landlord advance rent (the "Advance Rent") to be held by the Landlord without interest and to be applied on account of the first and last installments of Base Rent as they fall due and to be held to the extent not so applied as security for and which may be applied by the Landlord to the performance of the covenants and obligations of the Tenant under this Lease.

17. On execution of this Lease, The Tenant will pay the Landlord a security deposit equal to the amount of none, subject to purchase agreement earnest money of $10000.

Purchase Agreement

23. Provided the Tenant is not currently in default in the performance of any term of this Lease, the Tenant will purchase the Premises for $450,000.00 (the "Purchase Price") on or before December 31, 2017. See Attached Purchase Agreement. Upon the completion of the closing, all rights and obligations under the Lease (other than the Option) will cease to exist and the Parties will have no further rights or claims against each other concerning the Lease.

Quiet Enjoyment

25. The Landlord covenants that on paying the Rent and performing the covenants contained in this Lease, the Tenant will peacefully and quietly have, hold, and enjoy the Premises for the agreed term.

Renewal of Lease

26. Upon giving written notice no later than 60 days before the expiration of the term of this Lease, the Tenant may renew this Lease for an additional term. All terms of the renewed lease will be the same except for this renewal clause and the amount of the rent. If the Landlord and the Tenant

cannot agree as to the amount of the Rent, the amount of the Rent will be determined by mediation. If this lease is renewed the contract for sale shall be null and void.

Landlord Improvements

27. The Landlord will make those improvements to the Premises that are set out in the list attached to this Lease.

28. All improvements provided by the Landlord will revert back to the Landlord at the end of the Lease except for the following: All improvements required by Michael Brady, architect, for the facility to be utilized as a residential hospice. The tenant to pay $109000 for the improvements per the attached letter, owner to oversee completion. Any overage to be paid by tenant prior to occupancy.

Utilities and Other Costs

29. The Tenant is responsible for the direct payment of the following utilities and other charges in relation to the Premises: electricity, natural gas, water, sewer, telephone, Internet and cable.

30. The Tenant will also directly pay for the following utilities and other charges in relation to the Premises: trash pickup, any expenses assessed to the property.

Insurance

31. The Tenant is hereby advised and understands that the personal property of the Tenant is not insured by the Landlord for either damage or loss, and the Landlord assumes no liability for any such loss. The Tenant is advised that, if insurance coverage is desired by the Tenant, the Tenant should inquire of Tenant's insurance agent regarding a Tenant's Policy of Insurance.

32. The Tenant is responsible for insuring the Landlord's contents and furnishings in or about the Premises for either damage and/or loss for the benefit of the Landlord.

33. The Tenant is responsible for insuring the Premises for damage or loss to the structure, mechanical or improvements to the Building on the Premises for the benefit of the Tenant and the Landlord. Such insurance should include such risks as fire, theft, vandalism, flood and disaster.

34. The Tenant is responsible for insuring the Premises for liability insurance for the benefit of the Tenant and the Landlord.

35. The Tenant will provide proof of such insurance to the Landlord upon request.

Attorney Fees

36. In the event that any action is filed in relation to this Lease, the unsuccessful party in the action will pay to the successful party, in addition to all the sums that either party may be called on to pay, a reasonable sum for the successful party's attorney fees.

Governing Law

37. It is the intention of the Parties to this Lease that the tenancy created by this Lease and the performance under this Lease, and all suits and special proceedings under this Lease, be construed in accordance with and governed, to the exclusion of the law of any other forum, by the laws of the

State of Tennessee, without regard to the jurisdiction in which any action or special proceeding may be instituted.

Severability

38. If there is a conflict between any provision of this Lease and the applicable legislation of the State of Tennessee (the 'Act'), the Act will prevail and such provisions of the Lease will be amended or deleted as necessary in order to comply with the Act. Further, any provisions that are required by the Act are incorporated into this Lease.

Assignment and Subletting

39. Without the prior, express, and written consent of the Landlord, the Tenant will not assign this Lease, or sublet or grant any concession or license to use the Premises or any part of the Premises. A consent by Landlord to one assignment, subletting, concession, or license will not be deemed to be a consent to any subsequent assignment, subletting, concession, or license. An assignment, subletting, concession, or license without the prior written consent of Landlord, or an assignment or subletting by operation of law, will be void and will, at Landlord's option, terminate this Lease.

Maintenance

40. The Tenant will, at its sole expense, keep and maintain the Premises and appurtenances in good and sanitary condition and repair during the term of this Lease and any renewal of this Lease.

41. In particular, the Tenant will keep the fixtures in the Premises in good order and repair and keep the HVAC clean. The Tenant will, at Tenant's sole expense, make all required repairs to the plumbing, range, heating apparatus, and electric and gas fixtures whenever damage to such items will have resulted from the Tenant's misuse, waste, or neglect or that of the Tenant's employee, family, agent, or visitor.

42. The Tenant will be responsible at its own expense to replace all electric light bulbs, tubes, ballasts or fixtures serving the Premises.

43. Where the Premises has its own sidewalk, entrance, driveway or parking space which is for the exclusive use of the Tenant and its guests, the Tenant will keep the sidewalk, entrance, driveway or parking space clean, tidy and free of objectionable material including dirt, debris, snow and ice.

44. Where the Premises has its own garden or grass area which is for the exclusive use of the Tenant and its guests, the Tenant will water, fertilize, weed, cut and otherwise maintain the garden or grass area in a reasonable condition including any trees or shrubs in or about the Premises.

45. The Tenant will also perform the following maintenance in respect to the Premises: any and all maintenance.

Care and Use of Premises

46. The Tenant will promptly notify the Landlord of any damage, or of any situation that may significantly interfere with the normal use of the Premises.

47. Vehicles which the Landlord reasonably considers unsightly, noisy, dangerous, improperly insured, inoperable or unlicensed are not permitted in the Tenant's parking stall(s), and such vehicles may be towed away at the Tenant's expense. Parking facilities are provided at the Tenant's own risk. The Tenant is required to park in only the space allotted to them.

48. The Tenant will not make (or allow to be made) any noise or nuisance which, in the reasonable opinion of the Landlord, disturbs the comfort or convenience of other tenants.

49. The Tenant will not engage in any illegal trade or activity on or about the Premises.

50. The Landlord and Tenant will comply with standards of health, sanitation, fire, housing and safety as required by law.

General Provisions

52. Any waiver by the Landlord of any failure by the Tenant to perform or observe the provisions of this Lease will not operate as a waiver of the Landlord's rights under this Lease in respect of any subsequent defaults, breaches or nonperformance and will not defeat or affect in any way the Landlord's rights in respect of any subsequent default or breach.

53. This Lease will extend to and be binding upon and inure to the benefit of the respective heirs, executors, administrators, successors and assigns, as the case may be, of each party to this Lease. All covenants are to be construed as conditions of this Lease.

54. All sums payable by the Tenant to the Landlord pursuant to any provision of this Lease will be deemed to be Additional Rent and will be recovered by the Landlord as rental arrears.

55. Where there is more than one Tenant executing this Lease, all Tenants are jointly and severally liable for each other's acts, omissions and liabilities pursuant to this Lease.

IN WITNESS WHEREOF the Parties to this Lease have duly affixed their signatures under hand and by a duly authorized officer, on this _6__ day of January, 2013.

(Witness)

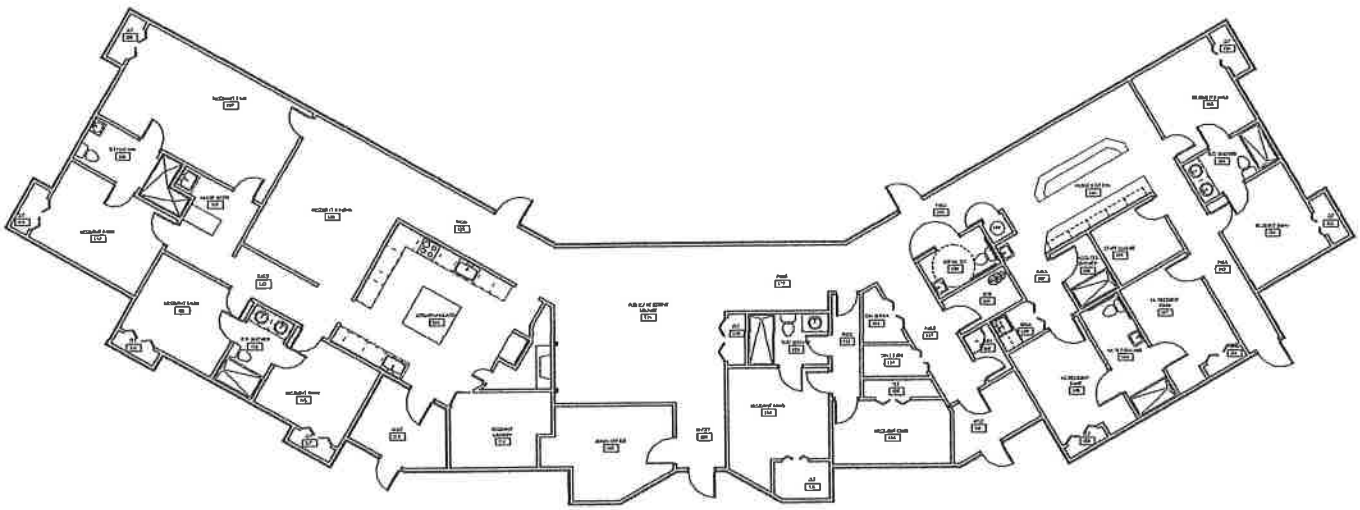
Jack and Constance Mitchell (Landlord)

(Witness)

Life House, LLC (Tenant)

Per: , V.P.

Attachment
B Projected Description, II A
Floor Plan

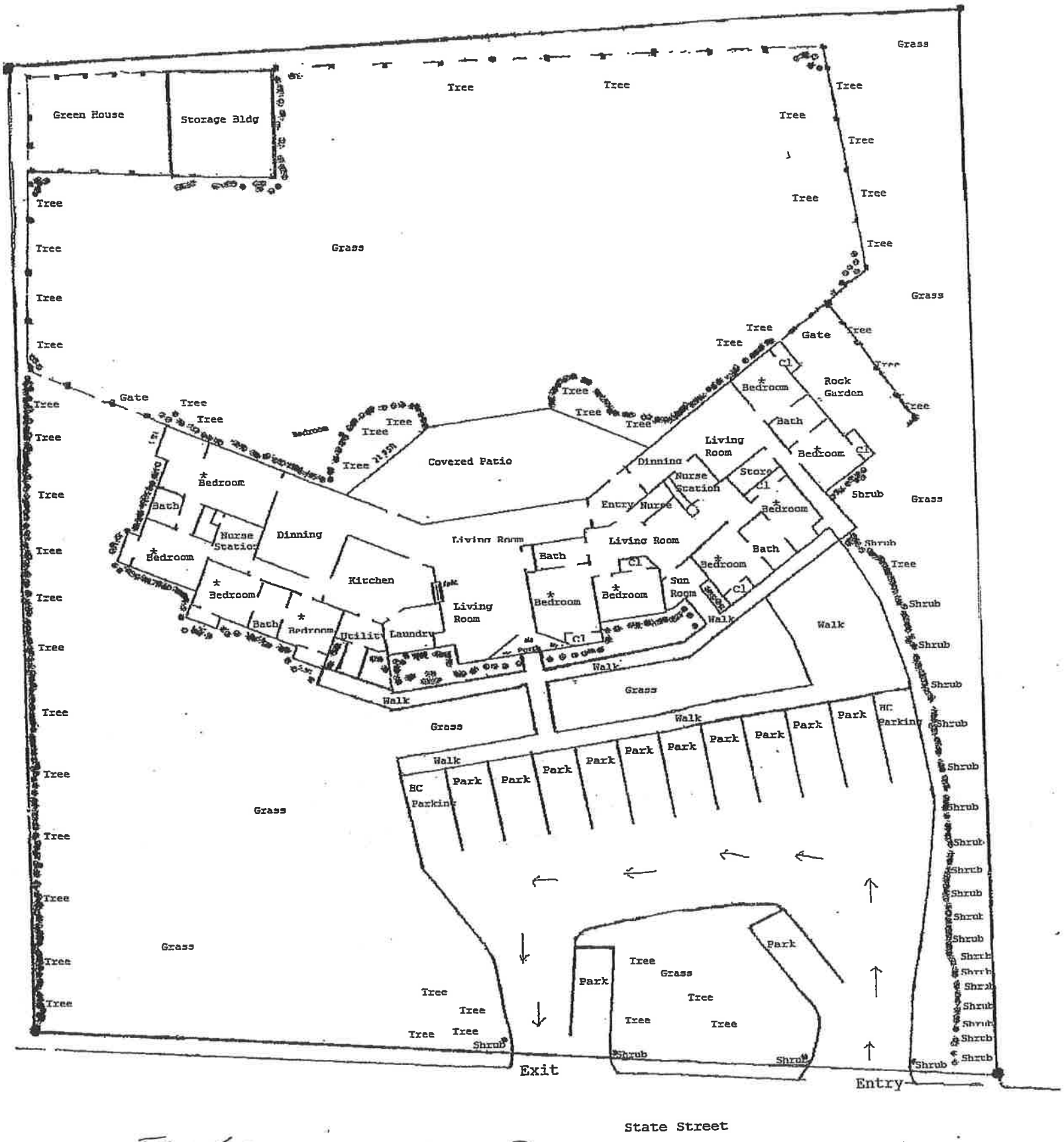


MBI
michael brady inc.

COOKEVILLE ADULT LIVING FACILITY AND HOSPICE, COOKEVILLE TENNESSEE

11/15/12

Attachment
B Project Description, III A
Plot Plan



570 STATE ST SITE PLAN LIFE HOUSE HOSPICE

CONNIE MITCHELL 881-6417

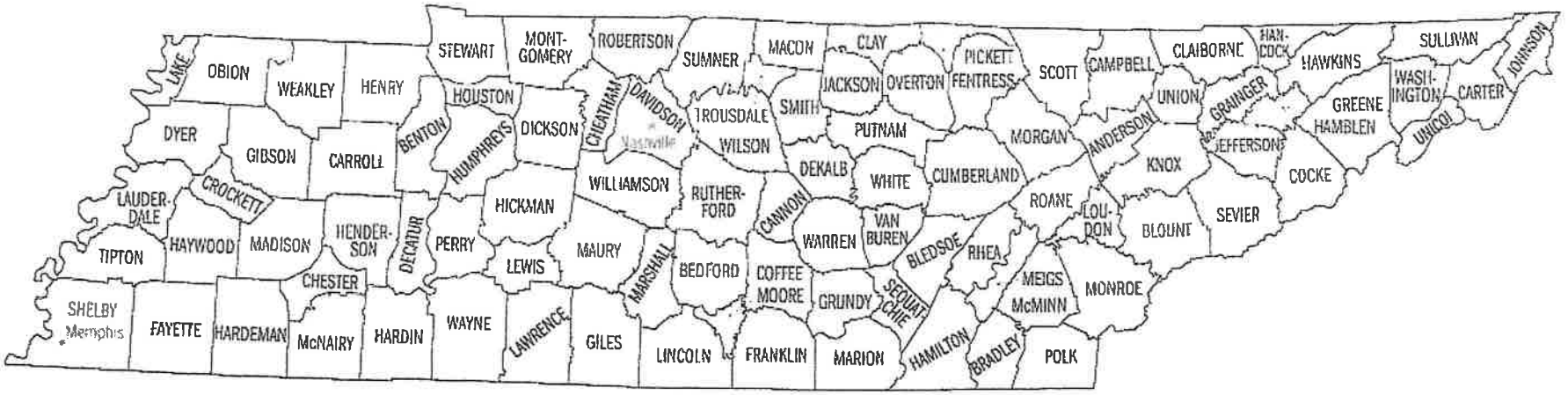
RICHARD BERHART 644-1785

--- 6' Wood Privacy Fence

---- Property Line

Attachment
C Criteria - Need, 3
Service Area Map

Tennessee County Selection Map



Attachment
C Economic Feasibility, 1 B-1
Residential Appraisal

RESIDENTIAL APPRAISAL-SUMMARY APPRAISAL RPT.

File No.:

SUBJECT

Property Address: 570 STATE STREET | City: COOKEVILLE | State: TN | Zip Code: 38501

County: PUTNAM | Legal Description: LOT #1 OF THE UPPER CUMBERLAND CHRISTIAN HOME DIVISION

Assessor's Parcel #: MAP 53 PARCEL 2.04

Tax Year: 2012 | R.E. Taxes: $ 2,865 | Special Assessments: $ | Borrower (if applicable): JACK & CONNIE MITCHELL

Current Owner of Record: JACK W. MITCHELL, ETUX CONSTANCE | Occupant: ☒ Owner ☐ Tenant ☐ Vacant | ☐ Manufactured Housing

Project Type: ☐ PUD ☐ Condominium ☐ Cooperative ☐ Other (describe) | HOA: $ ☐ per year ☐ per month

Market Area Name: SWEETLAND SUBDIVISION | Map Reference: MAP 53 | Census Tract:

2013 JAN 8 AM 11 52

ASSIGNMENT

The purpose of this appraisal is to develop an opinion of: ☒ Market Value (as defined), or ☐ other type of value (describe)

This report reflects the following value (if not Current, see comments): ☒ Current (the Inspection Date is the Effective Date) ☐ Retrospective ☐ Prospective

Approaches developed for this appraisal: ☒ Sales Comparison Approach ☐ Cost Approach ☐ Income Approach (See Reconciliation Comments and Scope of Work)

Property Rights Appraised: ☒ Fee Simple ☐ Leasehold ☐ Leased Fee ☐ Other (describe)

Intended Use: THIS APPRAISAL REPORT IS INTENDED FOR USE IN A LENDING RELATED MATTER TO THE SUBJECT PROPERTY. ITS USE BY OTHERS IS NOT INTENDED.

Intended User(s) (by name or type): PUTNAM 1ST MERCANTILE BANK

Client: PUTNAM 1ST MERCANTILE BANK | Address: 200 WEST JACKSON STREET, COOKEVILLE, TN 38501

Appraiser: MONTE GAW | Address: P.O. BOX 1275, COOKEVILLE, TN 38503

MARKET AREA DESCRIPTION

				Predominant Occupancy	One-Unit Housing			Present Land Use		Change in Land Use
Location:	☒ Urban	☐ Suburban	☐ Rural		PRICE $(000)		AGE (yrs)	One-Unit	60 %	☒ Not Likely
Built up:	☐ Over 75%	☒ 25-75%	☐ Under 25%	☒ Owner 65				2-4 Unit	%	☐ Likely * ☐ In Process *
Growth rate:	☐ Rapid	☒ Stable	☐ Slow	☒ Tenant 25	120'S	Low	12	Multi-Unit	20 %	* To:
Property values:	☐ Increasing	☒ Stable	☐ Declining	☒ Vacant (0-5%)	400'S	High	35	Comm'l	20 %	
Demand/supply:	☐ Shortage	☒ In Balance	☐ Over Supply	☐ Vacant (>5%)	200'S	Pred	20		%	
Marketing time:	☐ Under 3 Mos.	☐ 3-6 Mos.	☒ Over 6 Mos.							

Market Area Boundaries, Description, and Market Conditions (including support for the above characteristics and trends): THE SUBJECT PROPERTY IS LOCATED EAST OF SOUTH WILLOW AVENUE AT THE TERMINUS OF STATE STREET. THE IMMEDIATE AREA IS MADE UP OF A NUMBER OF LOW DENSITY RESIDENTIAL USES TO THE EAST AND SOUTH, WHILE THE ADJACENT USE TO THE WEST CONSISTS OF A MEDIUM DENSITY RESIDENTIAL USE. THE SUBJECT'S MARKET AREA BOUNDARIES ARE DEFINED AS THE AREA THAT CONTAINS ITS DIRECT COMPETITION, WHICH IN THE SUBJECT'S CASE, WOULD BE CONSIDERED THE CITY LIMITS OF COOKEVILLE IN ALL DIRECTIONS & ALONG ITS FRINGES. NO CHANGES ARE ANTICIPATED IN THE LAND USE PATTERN IN THE IMMEDATE AREA & IT SHOULD REMAIN PRIMARILY A LOW TO MEDIUM DENSITY RESIDENTIAL AREA, WITH THE MEDIUM RESIDENTIAL USE IN PLACE.

SITE DESCRIPTION

Dimensions: 200'X 232' IRREGULAR | Site Area: 43,560 SQ. FT.

Zoning Classification: RS-10 | Description: LOW DENSITY RESIDENTIAL

Zoning Compliance: ☒ Legal ☐ Legal nonconforming (grandfathered) ☐ Illegal ☐ No zoning

Are CC&Rs applicable? ☐ Yes ☐ No ☒ Unknown | Have the documents been reviewed? ☐ Yes ☐ No | Ground Rent (if applicable) $ /

Highest & Best Use as improved: ☒ Present use, or ☐ Other use (explain) THE SUBJECT'S HIGHEST & BEST USE WOULD BE FOR THE CONTINUATION OF THE PRESENT IMPROVEMENTS & RESIDENTIAL USE.

Actual Use as of Effective Date: SINGLE-FAMILY RESIDENTIAL | Use as appraised in this report: SINGLE-FAMILY RESIDENTIAL

Summary of Highest & Best Use: CONSIDERING THE SURROUNDING LAND USES, THE HIGHEST & BEST USE FOR THE SUBJECT WOULD BE SOME TYPE OF RESIDENTIAL USE, SUCH AS THE SINGLE FAMILY RESIDENCE IN PLACE.

Utilities	Public	Other	Provider/Description
Electricity	☒	☐	
Gas	☒	☐	
Water	☒	☐	
Sanitary Sewer	☒	☐	
Storm Sewer	☐	☐	

Off-site Improvements	Type	Public	Private
Street	PAVED	☒	☐
Curb/Gutter		☐	☐
Sidewalk		☐	☐
Street Lights		☒	☐
Alley		☐	☐

Topography	GENERALLY LEVEL
Size	1 ACRE
Shape	RECTANGULAR
Drainage	APPEARS ADEQUATE
View	GOOD

Other site elements: ☐ Inside Lot ☐ Corner Lot ☐ Cul de Sac ☐ Underground Utilities ☐ Other (describe)

FEMA Spec'l Flood Hazard Area ☐ Yes ☒ No FEMA Flood Zone X | FEMA Map # 47141C0120D | FEMA Map Date MAY 16, 2007

Site Comments: IT IS MY UNDERSTANDING THAT THE SUBJECT HAS RECEIVED APPROVAL, UNDER A SPECIAL EXCEPTION USE FROM THE BZA, TO BE CONVERTED TO A HOSPICE RESIDENCE HOME. THE ACTION FOR THIS WAS TAKEN IN THE NOVEMBER 2012 BOARD OF ZONING APPEALS MEETING, WHICH OCCURRED JUST AFTER THE EFFECTIVE DATE OF THIS APPRAISAL. A COPY OF THE RS-10 DISTRICT REGULATIONS IS INCLUDED IN THE ADDENDA OF THE REPORT.

IMPROVEMENTS

General Description		Exterior Description		Foundation		Basement ☒ None		Heating	
# of Units	1 ☐ Acc.Unit	Foundation	SLAB	Slab		Area Sq. Ft.		Type	CENTRAL
# of Stories	1	Exterior Walls	BRICK/SIDING	Crawl Space	NONE	% Finished		Fuel	ELECTRIC
Type ☒ Det. ☐ Att. ☐		Roof Surface	A. SHINGLE	Basement	NONE	Ceiling			
Design (Style)	RANCH	Gutters & Dwnspts.	METAL	Sump Pump ☐	N. OBSVD.	Walls		Cooling	CENTRAL
☒ Existing ☐ Proposed ☐ Und.Cons.		Window Type	COMBINATION	Dampness ☐	N. OBSVD.	Floor		Central	
Actual Age (Yrs.)	1982	Storm/Screens		Settlement	NONE OBSV.	Outside Entry		Other	
Effective Age (Yrs.)	10-12 YEARS			Infestation	NONE OBSV.				

RESIDENTIAL APPRAISAL-SUMMARY APPRAISAL RPT. File No.:

INCOME APPROACH

INCOME APPROACH TO VALUE (if developed) ☒ The Income Approach was not developed for this appraisal.

Estimated Monthly Market Rent $ X Gross Rent Multiplier = $ Indicated Value by Income Approach

Summary of Income Approach (including support for market rent and GRM):

PUD

PROJECT INFORMATION FOR PUDs (if applicable) ☐ The Subject is part of a Planned Unit Development.

Legal Name of Project:

Describe common elements and recreational facilities:

RECONCILIATION

Indicated Value by: Sales Comparison Approach $ 400,000 Cost Approach (if developed) $ Income Approach (if developed) $

Final Reconciliation NIETHER THE COST NOR INCOME CAPITALIZATION APPROACHES TO VALUE WERE DEVELOPED FOR THE APPRAISAL PROBLEM TO BE SOLVED. IT IS FELT THE DEVELOPMENT OF THE SALES COMPARISON APPROACH ALONE CAN LEAD TO A RELIABLE INDICATOR OF VALUE FOR THE SUBJECT PROPERTY.

This appraisal is made ☒ "as is", ☐ subject to completion per plans and specifications on the basis of a Hypothetical Condition that the improvements have been completed, ☐ subject to the following repairs or alterations on the basis of a Hypothetical Condition that the repairs or alterations have been completed, ☐ subject to the following required inspection based on the Extraordinary Assumption that the condition or deficiency does not require alteration or repair:

☐ This report is also subject to other Hypothetical Conditions and/or Extraordinary Assumptions as specified in the attached addenda.

Based on the degree of inspection of the subject property, as indicated below, defined Scope of Work, Statement of Assumptions and Limiting Conditions, and Appraiser's Certifications, my (our) Opinion of the Market Value (or other specified value type), as defined herein, of the real property that is the subject of this report is: $ 400,000 , as of: NOVEMBER 5, 2012 , which is the effective date of this appraisal. If indicated above, this Opinion of Value is subject to Hypothetical Conditions and/or Extraordinary Assumptions included in this report. See attached addenda.

ATTACHMENTS

A true and complete copy of this report contains 33 pages, including exhibits which are considered an integral part of the report. This appraisal report may not be properly understood without reference to the information contained in the complete report.

Attached Exhibits:

☒ Scope of Work	☒ Limiting Cond./Certifications	☐ Narrative Addendum	☒ Photograph Addenda	☒ Sketch Addendum
☒ Map Addenda	☐ Additional Sales	☐ Cost Addendum	☐ Flood Addendum	☐ Manuf. House Addendum
☐ Hypothetical Conditions	☐ Extraordinary Assumptions	☐	☐	☐

SIGNATURES

Client Contact: KELLY GORE Client Name: PUTNAM 1ST MERCANTILE BANK

E-Mail: Address: 200 WEST JACKSON STREET, COOKEVILLE, TN 38501

APPRAISER

Appraiser Name: MONTE GAW

Company: MONTE GAW APPRAISAL SERVICE

Phone: 931-528-0394 Fax: 931-528-0394

E-Mail: montegaw@gmail.com

Date of Report (Signature): NOVEMBER 20, 2012

License or Certification #: CG-1182 State: TN

Designation: TENNESSEE CERTIFIED GENERAL R.E. APPRAISER

Expiration Date of License or Certification: 08/31/2014

Inspection of Subject: ☒ Interior & Exterior ☐ Exterior Only ☐ None

Date of Inspection: NOVEMBER 5, 2012

SUPERVISORY APPRAISER (if required) or CO-APPRAISER (if applicable)

Supervisory or Co-Appraiser Name:

Company:

Phone: Fax:

E-Mail:

Date of Report (Signature):

License or Certification #: State:

Designation:

Expiration Date of License or Certification:

Inspection of Subject: ☐ Interior & Exterior ☐ Exterior Only ☐ None

Date of Inspection:

Attachment
C Economic Feasibility, 1 D-1
Architect Letter

Michael Brady Inc.

299 N. Weisgarber Road, Knoxville, TN 37919-4013
(865) 584-0999, Fax: (865) 584-5213, E-mail: mbi@mbiarch.com

November 15, 2012

Mr. Richard Gerhart
570 State Street
Cookeville, TN 38501

Re: Cookeville Adult Living Facility
Cookeville, Tennessee
MBI Comm No: CG120393

Dear Mr. Gerhart:

Please see attached Schematic floor plan that MBI has developed to modify the existing building to an Adult Living and Hospice Facility. This schematic floor plan is for use in your Certificate of Need (CON) Submittal, but is not an approved plan for construction. Also attached is space program developed per discussions about proposed services for this facility, and 2010 Guidelines for Design and Construction of Healthcare Facilities.

The existing building is approximately 4,450 square feet with approximately 1,050 square feet having major renovations and approximately 3,400 square feet having minor renovations or finish upgrades. Based upon our experience and knowledge of current construction market, it is our opinion that the construction cost for building modifications will be approximately $90,000, site and parking modifications of approximately $5,000, and installation of new fire sprinkler system of approximately $14,000. It is our opinion that total construction cost will be approximately $109,000.

Below is a summary of building codes and regulations anticipated to be enforced for this project. This listing may not be entirely inclusive, but the intent is for all applicable codes and regulations being enforced by State and Local agencies at the time of plans submitted to be addressed during the design process.

- Guidelines for the Design and Construction of Health Care Facilities.
- Rules of Tennessee Department of Health Board of Licensing Health Care Facilities.
- International Building, Mechanical, Plumbing, and Gas Codes
- National Electrical Code
- National Fire Protection Code (NFPA)
- Americans with Disabilities Act (ADA)

Please include this floor plan with your Certificate of Need (CON) Submittal and this letter as documentation of Probable cost for Construction of this project. Please contact me if there are any questions.

Sincerely,
Michael Brady Inc.

Jay H. Henderlight, AIA
Architect, TN Lic. No. 17136

Michael Brady Inc.
299 N. Weisgarber Road, Knoxville, TN 37919-4013
(865) 584-0999, Fax: (865) 584-5213, E mail: mbi@mblarch.com

Cookeville Adult Living Facility and Hospice Program

MBI Comm No: 120393

1. Resident Rooms
   - 10 Bedrooms (Single Bedrooms)
   - Window at each sleep room
   - Hand-washing in adjacent Toilet
   - Wardrobe or closet min 1'-10" x 2'-6" with rod and shelf

2. Resident Toilet Rooms
   - 5 Toilets (Shared between 2 Resident Sleep Rooms)
   - Toilet, Lavatory, Mirror
   - Storage for personal items each patient
   - Privacy locks with Emergency Access Function
   - Develop at minimum one HC access/ toilet for resident access.

3. Resident Bathing Facilities
   - Provide one Assisted Bathing Room (HC Accessible)
   - Shower shall accommodate a shower gurney

4. Nurse Station
   - Central Nurse Station located near 6 Hospice Resident Rooms
   - Decentralized Nurse Work Station located near 4 Home for Aged Residents Rooms

5. Medication Room
   - Storage of Medical Supplies and Narcotics
   - Work Counter, sink, refrigerator, and locked storage for controlled drugs
   - Minimum area 50 sf.

6. Resident Dining Room
   - Space for table and chairs for 10 to 12 people

7. Resident Kitchen (County Kitchen)/ Nourishment Center
   - Range/ oven with emergency shut-offs
   - Refrigerator
   - Storage Cabinets and work counters
   - Sink
   - Dishwasher
   - Food-warming (Microwave)
   - Handwash station
   - Ice Making Equipment

8. Resident Laundry
   - Washer and Dryer for laundry of residents personal clothing

9. Clean Linen Room
   - Space for storing clean sheets and towels, etc. from private linen service

10. Clean Supply Room
    - Countertop and storage cabinets or shelves for clean and sterile supplies storage

11. Soiled Holding Room/ Janitor Storage
    - Space for waste receptacles and soiled linen hampers
    - Flushing-rim fixture with bed pan rinsing hose
    - Handwash sink.
    - Space for janitor cart and cleaning supplies

12. Equipment Storage
    - Space for wheelchair and other equipment such as lift storage provided away from normal traffic.

13. Staff Lounge and Toilet

14. Public/ Resident Lounge Area

15. Administrative Office

Attachment
C Economic Feasibility, 2F-1
Funds Letter CFO

Life House, LLC

570 State St. Cookeville, TN 38501

January 2, 2013

Health Services and Development Agency
500 Deadrick St, Suite 850
Nashville, TN 37243

RE: CON Application for Residential Hospice

Life House, LLC has sufficient cash reserves to fund all the necessary costs to initiate residential hospice services as outlined in this application. The estimated required capital for start up is expected to be $33000 and funds have been dedicated for that purpose. Additional investors are ready to purchase shares of Life House, LLC in excess of $200000 upon approval of the CON. Any addition funds needed for reserves for operating capital will come from sales of additional shares if needed.

Respectfully,

Jack Mitchell, CFO
Life House, LLC

Attachment
C Economic Feasibility, 10
CPA Data

DIA

DANIELS, IRWIN & AYLOR CERTIFIED PUBLIC ACCOUNTS

December 31, 2012

To The Members
Life House, LLC
Cookeville, Tennessee

We have compiled the accompanying forecasted 2013 and 2014 Revenue and Expenses of Life House, LLC as of December 31, 2013 and 2014, and for the year then ending, in accordance with attestation standards established by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form of a forecast information that is the representation of management and does not include evaluation of the support for the assumptions underlying the forecast. We have not examined the forecast and, accordingly, do not express an opinion or any other form of assurance on the accompanying statements or assumptions. Furthermore, there will usually be differences between the forecasted and actual results because event and circumstances frequently do not occur as expected, and those differences may be material. We have no responsibility to update this report for events and circumstances occurring after the date of this report.

Cleston Daniels, CPA
Daniels, Irwin and Aylor, PC

223 Madison Street, Suite 112 Madison, TN 37115-3660 (615) 868-6008 FAX (615) 868-2071
An Association of CPA's

DIA

DANIELS, IRWIN & AYLOR CERTIFIED PUBLIC ACCOUNTS

December 31, 2012

Life House, LLC

Forecast Statement of Revenue and Expenses

Revenue	12/31/2013	12/31/2014
Patient Days	1500	3000
Routine rate	$424196	$876392
In Patient	175854	351,708
Private Donations	500	500
Memorial Donations	2500	2500
Auxiliary Donations	25000	25000
Gross Revenue	628050	1256100
Expenses		
Labor		
RN, LPN, CAN	201147	255474
Admin/Medical Director	85000	100000
Taxes/Benefits	53250	69325
Background/training	1500	2000
Total Labor	$ 340897	$ 426799

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An Association of CPA's

DIA

DANIELS, IRWIN & AYLOR CERTIFIED PUBLIC ACCOUNTS

Patient Expenses		
Pharmacy	44800	64682
Therapy/Lab	30000	40000
Medical Supplies	20000	35000
Meals/food	8000	16000
Laundry	2500	3000
Medical Waste disposal	4000	4000
Total Patient Expenses	**109300**	**162682**
General Operating Expenses		
Rent	45000	45000
Insurance	4000	4000
Maintenance/repairs	1000	1000
Grounds upkeep	1000	1000
General supplies	6500	6500
Utilities	8600	9600
Phone/internet	3000	3000
Office/bookkeeping	6500	8000
Marketing	4500	4500
Mileage	1000	1000
Bad Debt/Charity	11984	23160
Miscellaneous	10000	20000
Total Operating Expenses	**$103084**	**$106760**
Reserves-building purchase	**0**	**250000**
TOTAL EXPENSES	**$553281**	**$966311**
EXCESS REVENUE OVER EXPENSES	**$74769**	**$289789**

223 Madison Street, Suite 112 Madison, TN 37115-3660 (615) 868-6008 FAX (615) 868-2071
An Association of CPA's

Life House, LLC — Balance Sheet

Assets		
Current assets:	**2012**	**2013**
Cash	-	20,000.00
investment -zoning, con, architect	54,000.00	54,000.00
Inventories	-	-
Accounts receivable Stock Sale	-	100,000.00
Pre-paid expenses	-	-
Other Donation payable	-	35,000.00
Total current assets	**54,000.00**	**209,000.00**
Fixed assets:	**2012**	**2013**
Property and equipment		450,000.00
Leasehold improvements		109,000.00
beds,furnishings and equipment	-	45,000.00
Less accumulated depreciation	-	-
Total fixed assets	-	**604,000.00**
Other assets:	**2012**	**2013**
	-	
Total other assets	-	-
Total assets	**54,000.00**	**813,000.00**
Liabilities and owner's equity		
Current liabilities:	**2012**	**2013**
Accounts payable	-	
Accrued wages	-	-
Accrued compensation	-	-
Income taxes payable	-	-
Unearned revenue	-	
reserve for stocks and donations	-	135,000.00
Total current liabilities	-	**135,000.00**
Long-term liabilities:	**2012**	**2013**
Purchase agreement		450,000.00
Total long-term liabilities	-	**450,000.00**
Owner's equity:	**2012**	**2013**
Investment capital	54,000.00	228,000.00
Accumulated retained earnings	-	-
Total owner's equity	**54,000.00**	**228,000.00**
Total liabilities and owner's equity	**54,000.00**	**813,000.00**

Balance - -

Attachment
Proof of Publication
Herald Citizen

Legals

ICE OF SALE

en made in the
ots and obliga-
be paid by a
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and Debbie L.
and wife, and
s and Jennifer
d and wife, on
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ord Book 419,
n O. Johnson
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Deed of Trust.

PUTNAM COUNTY PROPERTY: The phrase "Putnam County Property" as used herein shall mean all of the Grantor's right, title and interest in an to the following described real property (together with all existing or subsequently erected or affixed improvements and fixtures, all appurtenant easements and rights of way, and other appurtenances) described as follows:

LEGAL DESCRIPTION:
TRACT I: Quit Claim Deed from Randal R. Way to Michelle Way Coe, of record in Deed Book 446, Page 45.

TRACT II: Special Warranty Deed from Secretary of Veterans Affairs to Robert G. Coe and wife, Michelle D. Coe, of record in Deed Book 430, Page 535. (Lots 10 & 11 South Hills Estates)

COMMON DESCRIPTION:
TRACT I: Tax Map 71-H, Group A, Parcel 6.08
Address: Poplar Street, Monterey, TN 38574

TRACT II: Tax Map 82-M, Group A, Parcels 10.00 & 11.00

IN THE EVENT THE HIGHEST BIDDER DOES NOT CLOSE THE SALE WITHIN THE TIME PROVIDED, THE TRUSTEE RESERVES THE RIGHT TO CLOSE THE SALE WITH THE NEXT HIGHEST BIDDER AT THE NEXT HIGHEST BID.

OTHER INTERESTED PARTIES: An examination of title shows the following: 1) LVNV Funding LLC has recorded a Judgment Lien against Robert Coe, which appears of record at Record Book 650, page 343, Register's Office, Putnam County, Tennessee. With respect to said lien, notice is hereby given of the pending foreclosure sale and the resulting discharge of said lien as to the above described property.

This 20th day of December, 2012.

/s/ Jack P. Ray, Trustee___
Jack P. Ray, Trustee
12/28, 1/4, 1/11

005 Public Notices

I MIKE MARCUM am responsible for only the debts of myself from the date of 12/27/12

025 Special Notices

FOR YOUR CONVENIENCE

The Herald Citizen has installed an after hours drop box for
- Circulation Dept. payments
- Classified Dept. payments

110 Construction Work

ONE CALL IMPROVEMENTS
SUMMER DECK SPECIAL
Best Prices! We also do all Int/Ext home improvements.
Call (931)854-0263

FLATT CONSTRUCTION Additions, garages, decks, porches, kitchens, baths. Refs, Ins/Lic, Free Est. Accept major credit cards. **528-0426 / 265-5687**
affordablebuilders@live.com

WHEET CONSTRUCTION Res. & Comm framing, decks or roof over decks, screen porches, additions, home repairs Refs, Lic'd & Ins'd. Jeremiah **(931)854-6692**

DOWNS CONSTRUCTION
25 years experience in home repairs, roofing and decks
Licensed & Insured.
931-267-0269

120 Painting/Wallpaper

PAINTING / STAINING / PAPER HANGING, pressure washing, drywall repair. 37 yrs exp. ***Exc. Ref's.*** Call **David,** Muddy Pond, **931-445-3796** or **265-0639.**

KERBY PAINTING
Highly recommended painter. Specializing in Ext/Int painting, SR finishing & pressure washing. Refs upon request. 3rd generation, Lic'd / Ins'd / Bonded

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq*, and the Rules of the Health Services and Development Agency, that Life House, LLC,, owned by Life House, LLC with an ownership type of Limited Liability Company and to be managed by Life House, LLC intends to file an application for a Certificate of Need for the proposed project is located at 570 State St., Cookeville, TN 38501. It is proposed to be a 4,450 square foot, 10 bed residential hospice facility to serve Putnam and eight surrounding counties. The project does not contain any major medical equipment and will not initiate nor discontinue any other health services. The project cost is approximately $600,000.

The anticipated date of filing the application is 01/02/2013. The contact person for this project is Connie Mitchell, President who may be reached at Life House, LLC, 570 State St., Cookeville, TN 38501, 931-881-6417.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building - 500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published letter of intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SEE ORIGINAL
8/17

AFFIDAVIT

STATE OF TN

COUNTY OF Putnam

2013 JAN 8 AM 11 52

Constance J Mitchell, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

TONYA J. REEDER
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF PUTNAM

Constance Mitchell
SIGNATURE/TITLE President

Sworn to and subscribed before me this 2nd day of January (Month) 2013 (Year) a Notary

Public in and for the County/State of Putnam / TN.

Tonya Reeder
NOTARY PUBLIC

My commission expires April 24 (Month/Day), 2015 (Year).

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

March 1, 2013

Connie Mitchell, President
Life House, LLC
570 State Street
Cookeville, TN 38501

RE: Certificate of Need Application -- Life House, LLC - CN1301-001

Dear Ms. Mitchell:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the establishment of a ten (10) bed residential hospice. The estimated project cost is $600,000.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on March 1, 2013. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on May 22, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Lori B. Ferranti, TDH, PPA

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

MEMORANDUM

TO: Lori B. Ferranti, Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: March 1, 2013

RE: Certificate of Need Application
Life House, LLC - CN1301-001

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on March 1, 2013 and end on May 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact Mark Farber, Deputy Director.

Enclosure

cc: Connie Mitchell, President

2013 JAN -3 AM 11:46

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Herald Citizen (Name of Newspaper) which is a newspaper of general circulation in Putnam (County), Tennessee, on or before 01/05/ (Month / day), 20 13 (Year) for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Life House, LLC (Name of Applicant) (Facility Type-Existing)

owned by: Life House, LLC with an ownership type of Limited Liability Company and to be managed by: Life House, LLC intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

The proposed project is to be a 4450 square foot, 10 bed residential hospice facility. The facility is located at 570 State, Cookeville, Tn 38501. The project will serve Putnam and eight surrounding counties. The project does not contain any major medical equipment and will not initiate nor discontinue any other health services. The project cost is approximately $600,000.

The anticipated date of filing the application is: 01/10, 20 13

The contact person for this project is Connie Mitchell (Contact Name) President (Title)

who may be reached at: Life House, LLC (Company Name) 570 State St (Address)

Cookeville (City) Tn (State) 38501 (Zip Code) 931-881-6417 (Area Code / Phone Number)

Connie Mitchell (Signature) 01/03/2013 (Date) cjmitchell0347@gmail.com (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

January 17, 2013

Connie Mitchell
Director/President
Life House, LLC
570 State Street
Cookeville, TN 38501

RE: Certificate of Need Application CN1301-001
Life House, LLC

Dear Ms. Mitchell,

This will acknowledge our January 8, 2013 receipt of your application for a Certificate of Need for the establishment of a ten (10) bed residential hospice and the initiation of residential hospice services to be located at 570 State Street, Cookeville (Putnam County), TN 38501.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Wednesday, January 23, 2013. If the supplemental information requested in this letter is not submitted by or before this time, consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Applicant Profile, Item 4**

   The applicant facility's corporate charter is noted. Please submit documentation from the Tennessee Secretary of State that acknowledges and verifies the type of ownership as identified by the applicant.

   Please describe the existing or proposed ownership structure of the applicant including an ownership structure organizational chart.

   Please explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant.

As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more interest.

Please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, 68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

2. **Section A, Applicant Profile, Item 5**

The applicant has indicated there will not be a management/operating entity for the proposed project. The applicant has provided the resumes of the four (4) directors of Life House, LLC. The four (4) resumes provided appear to not have any experience listed in residential hospice services. Please describe the applicant's experience in providing management services for residential hospice services.

3. **Section A, Applicant Profile, Item 13**

Please clarify if the applicant has contacted UHC Community Plan, AmeriGroup or TennCare Select regarding possibly contracting for Residential Hospice Services.

4. **Section B, Project Description, Item I.**

The applicant notes 3.15 registered nurse FTEs in the Project Description. Please clarify why "LPN" is listed as a labor expense by DIA, Certified Public Accountants on page 78 of the application.

Please describe the bereavement services that will be offered.

Please describe the hospice levels of care.

Please clarify if the applicant is required to be a certified hospice, or affiliated with a Medicare certified hospice, to receive Medicare reimbursement for Residential Hospice Services.

Please define Residential Hospice Care.

5. **Section B, Project Description, Item IV. (floor plan)**

Please provide a revised floor plan that "zooms in" enough so that the room labels are readable.

Please indicate the size of the patients rooms and if they will be private.

Please indicate if all the restroom facilities will be full baths. Will two patient rooms share a restroom?

Please indicate where the locations of the restroom facilities are for staff and visitors.

6. **Section B, Project Description, Item II A.**

The provided square footage and cost per square forage chart is noted. The applicant has placed the total project cost ($600,000) as the construction/renovation cost. Please

resubmit the chart that reflects only actual renovation/construction cost and recalculate the Proposed Final Cost/SF.

7. **Section B, Project Description, Item II C.**

   The applicant has stated patients and their families must travel to Crossville, Knoxville, or Nashville to access residential hospice services. Please list the Hospice Providers the applicant is referencing and their licensed occupancy rates for 2011.

8. **Section B, Project Description, Item III.A.(Plot Plan)**

   Please indicate the size of site (in acres) on the plot plan and re-submit.

9. **Section C, Need Item 1**

   Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Please list the principles and provide a response to each.

10. **Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Services**

    Please provide a response to each criterion and standard that are applicable to the proposed project (Residential Hospice Services).

11. **Section C, Need, Item 3**

    The provided county map of Tennessee is noted. However, please submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on an 8 ½" x 11" sheet of white paper marked only with ink detectable by a standard photocopier.

12. **Section C, Need, Item 4.A.**

    Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	Clay	DeKalb	Jackson	*Macon*	*Overton*	Pickett	Putnam	Smith	White	Service Area	Tennessee
Current Year (CY), Age 65+											
Projected Year (PY), Age 65+											
Age 65+, % Change											
Age 65+, % Total (PY)											
CY, Total Population											
PY, Total Population											
Total Pop. % Change											
TennCare Enrollees											
TennCare Enrollees as a % of Total Population											
Median Age											
Median Household Income											
Population % Below Poverty Level											

13. Section C, Need, Item 4.B.

Please describe any special needs of the service area population including health disparities, accessibility to services, women, racial and ethnic minorities, and low income groups. In your response, please document how the applicant will take into consideration the special needs of the service area population.

Please indicate how this proposed project will benefit those patients and/or families without access to transportation that are in need of a local residential hospice.

14. Section C, Need, Item 6

The provided projected utilization and/or occupancy statistics is noted. However, the methodology must include detailed calculations or documentation from referral sources.

Completing the charts below should assist in providing the requested details:

Table 1

Year	Admissions	Patient Days	Average Daily Census	Average Length of Stay	Facility Occupancy
YR 1					
YR 2					

Table 2 - please provide an age distribution by clinical condition admission type for Year 1:

Disease Classification	55 and younger	56-65	66-84	85 & older
Cancer				
Heart Disease				
General debility				
Dementia				
Lung Disease				
Stroke				
Kidney Disease				
Other				
Total				

15. Section C, Economic Feasibility, Item 1

The residential appraisal is noted. The report notes the property is in FEMA (Federal Emergency Management Agency) flood zone "X". Please describe this designation and indicate the possible risk of flooding to the proposed project's location.

Please discuss why the applicant needed to receive special exception to be converted to a hospice residence home from the local board of zoning.

16. Section C, Economic Feasibility, Item 2 (Funding)

The letter from the applicant's CFO is noted. Please clarify if the $33,000 designated for start-up cost will come from the initial sale of shares in the corporation in the amount of $100,000.

The statement additional investors are ready to purchase shares in Life House, LLC in excess of $200,000 upon approval of the CON is noted. Please identify the additional investors and indicate the reason why there will be a need for additional investment. In addition, will this additional purchase of shares change the ownership structure of the LLC?

17. Section C, Economic Feasibility, Item 1 (Project Cost Chart)

The applicant has provided projects from 2007 to compare proposed project costs. Please compare the cost per square foot of construction to more recently similar approved projects such as CN0906-026A Hospice of Chattanooga, Inc. and CN0810-77A Hospice of Cumberland County d/b/a Cumberland House.

18. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Please explain why there are no contractual adjustments.

Please clarify if salaries and wages in the amount of $310,897 includes 24 hour nursing care.

Please clarify what the retirement of $250,000 in principal in Year Two represents.

Please specify the unit of measure for line A. Utilization Data. Please revise and resubmit the Projected Data Chart.

19. Section C, Economic Feasibility, Item 6.A

Please provide the proposed charge schedules for the proposal. Please also describe the anticipated revenue from the proposed project.

Please clarify if room and board will be reimbursed by Medicare. If not, how is room and board paid? Please clarify which HCPCS Codes (Q5001-Q5009) will be billed to Medicare.

20. Section C, Economic Feasibility, Item 6.B

The average daily charge schedule is noted. Please provide the certificate of need number for each project and date approved by the agency.

Since the applicant will be providing care to Medicare recipients, please compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code (s).

21. Section C, Economic Feasibility, Item 7

Please discuss the methodology used to come to the conclusion utilization of 50% will be sufficient to breakeven in Year One and a utilization rate of 82% will generate a significant positive cash flow in Year Two of the proposed project.

22. Section C, Economic Feasibility, Item 8

The statement "we have numerous investors ready to purchase shares of the corporation, once the CON is approved, which will give us ample operating capital if required" is noted. Please provide letters of capital commitment from those investors and documentation of the available funds.

23. Section C, Economic Feasibility, Item 9

Please discuss how medically indigent patients will be served by the proposed project.

24. Section C, Economic Feasibility, Item 10

The attached balance sheets located in Attachment C. from Clenton Daniels, CPA is noted. Please define the following categories totaling $628,050 as listed under "Revenue": Routine Rate $424,196; In Patient $175,854; Private Donations; $500; Memorial donations; $2,500 and Auxiliary Donations. If needed, please revise the Projected Data Chart under "B. Revenue from Services to patients" that will possibly more accurately categorize revenue.

Please clarify what Private, Memorial, and Auxiliary donations in the amount of $28,000 will be designated for. Also, are these donations recurring each year?

25. Section C, Economic Feasibility, Item 11

Please describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative. What were the alternatives considered prior to the building being completed and furnished?

26. Section C, Orderly Development, Item 1

Please be more specific in responding to this question. Please list the names of all existing health care providers (e.g. hospitals, nursing homes, home care organizations, hospice providers, etc.), managed care organization, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services. Responding to the question by stating the applicant will work with three medical centers and unknown home health and hospice care givers is not an adequate response.

27. Section C, Orderly Development, Item 3

The overall staffing chart is noted. The FTEs in the chart total 7.4 while the narrative response list 8.65 FTE employees, please clarify.

Please clarify if a chaplain, dietician or bereavement counselor will be employed. If not, how will these professionals be accessed by patients?

Please discuss the rationale of paying registered nurses and a social worker under the median wage as provided by the State of Tennessee Department of Labor and Workforce Development.

28. Section C, Orderly Development, Item 4

Please discuss the availability of registered nurses and a social worker while the applicant is planning to pay an hourly wage below the median hourly wage.

Please clarify if the facility is required to provide 24 hour nursing care. If so, was this considered in developing the expected staffing pattern of the proposed project?

What will be the shifts for medical staff?

Please indicate if a Medical Director has been identified. If so, please provide the name of the physician and documentation of his/her qualifications.

29. Section C, Orderly Development, Item 7

The applicant notes the facility will be accredited by the Community Health Accreditation Program (CHAP). Please describe CHAP.

Please indicate the total estimated accreditation cost (including application fees, yearly accreditation fees, site visit fees, etc.). Please clarify if the accreditation expense was accounted for in the projected data chart.

30. Project Completion Forecast Chart

The applicant has listed April 1, 2013 as the Agency projected Initial Decision date. The agency meeting for the month of April is scheduled for April 24, 2013. Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision to each phase of the completion forecast. Please adjust the Project Completion Forecast chart and resubmit.

Please clarify if the applicant is possibly too ambitious in initiating service in April 2013 since the applicant must be Medicare certified in order to render care to Medicare and TennCare patients.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Monday March 18, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

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Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

January 17, 2013

Connie Mitchell
Director/President
Life House, LLC
570 State Street
Cookeville, TN 38501

RE: Certificate of Need Application CN1301-001
Life House, LLC

Dear Ms. Mitchell,

This will acknowledge our January 8, 2013 receipt of your application for a Certificate of Need for the establishment of a ten (10) bed residential hospice and the initiation of residential hospice services to be located at 570 State Street, Cookeville (Putnam County), TN 38501.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Wednesday, January 23, 2013. If the supplemental information requested in this letter is not submitted by or before this time, consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Applicant Profile, Item 4**

   The applicant facility's corporate charter is noted. Please submit documentation from the Tennessee Secretary of State that acknowledges and verifies the type of ownership as identified by the applicant.

   Please describe the existing or proposed ownership structure of the applicant including an ownership structure organizational chart.

   Please explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant.

As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more interest.

Please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, 68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

2. **Section A, Applicant Profile, Item 5**

The applicant has indicated there will not be a management/operating entity for the proposed project. The applicant has provided the resumes of the four (4) directors of Life House, LLC. The four (4) resumes provided appear to not have any experience listed in residential hospice services. Please describe the applicant's experience in providing management services for residential hospice services.

3. **Section A, Applicant Profile, Item 13**

Please clarify if the applicant has contacted UHC Community Plan, AmeriGroup or TennCare Select regarding possibly contracting for Residential Hospice Services.

4. **Section B, Project Description, Item I.**

The applicant notes 3.15 registered nurse FTEs in the Project Description. Please clarify why "LPN" is listed as a labor expense by DIA, Certified Public Accountants on page 78 of the application.

Please describe the bereavement services that will be offered.

Please describe the hospice levels of care.

Please clarify if the applicant is required to be a certified hospice, or affiliated with a Medicare certified hospice, to receive Medicare reimbursement for Residential Hospice Services.

Please define Residential Hospice Care.

5. **Section B, Project Description, Item IV. (floor plan)**

Please provide a revised floor plan that "zooms in" enough so that the room labels are readable.

Please indicate the size of the patients rooms and if they will be private.

Please indicate if all the restroom facilities will be full baths. Will two patient rooms share a restroom?

Please indicate where the locations of the restroom facilities are for staff and visitors.

6. **Section B, Project Description, Item II A.**

The provided square footage and cost per square forage chart is noted. The applicant has placed the total project cost ($600,000) as the construction/renovation cost. Please

resubmit the chart that reflects only actual renovation/construction cost and recalculate the Proposed Final Cost/SF.

7. **Section B, Project Description, Item II C.**

   The applicant has stated patients and their families must travel to Crossville, Knoxville, or Nashville to access residential hospice services. Please list the Hospice Providers the applicant is referencing and their licensed occupancy rates for 2011.

8. **Section B, Project Description, Item III.A.(Plot Plan)**

   Please indicate the size of site (in acres) on the plot plan and re-submit.

9. **Section C, Need Item 1**

   Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Please list the principles and provide a response to each.

10. **Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Services**

    Please provide a response to each criterion and standard that are applicable to the proposed project (Residential Hospice Services).

11. **Section C, Need, Item 3**

    The provided county map of Tennessee is noted. However, please submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on an 8 ½" x 11" sheet of white paper marked only with ink detectable by a standard photocopier.

12. **Section C, Need, Item 4.A.**

    Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	Clay	DeKalb	Jackson	*Macon*	*Overton*	Pickett	Putnam	Smith	White	Service Area	Tennessee
Current Year (CY), Age 65+											
Projected Year (PY), Age 65+											
Age 65+, % Change											
Age 65+, % Total (PY)											
CY, Total Population											
PY, Total Population											
Total Pop. % Change											
TennCare Enrollees											
TennCare Enrollees as a % of Total Population											
Median Age											
Median Household Income											
Population % Below Poverty Level											

13. Section C, Need, Item 4.B.

Please describe any special needs of the service area population including health disparities, accessibility to services, women, racial and ethnic minorities, and low income groups. In your response, please document how the applicant will take into consideration the special needs of the service area population.

Please indicate how this proposed project will benefit those patients and/or families without access to transportation that are in need of a local residential hospice.

14. Section C, Need, Item 6

The provided projected utilization and/or occupancy statistics is noted. However, the methodology must include detailed calculations or documentation from referral sources.

Completing the charts below should assist in providing the requested details:

Table 1

Year	Admissions	Patient Days	Average Daily Census	Average Length of Stay	Facility Occupancy
YR 1					
YR 2					

Table 2 - please provide an age distribution by clinical condition admission type for Year 1:

Disease Classification	55 and younger	56-65	66-84	85 & older
Cancer				
Heart Disease				
General debility				
Dementia				
Lung Disease				
Stroke				
Kidney Disease				
Other				
Total				

15. Section C, Economic Feasibility, Item 1

The residential appraisal is noted. The report notes the property is in FEMA (Federal Emergency Management Agency) flood zone "X". Please describe this designation and indicate the possible risk of flooding to the proposed project's location.

Please discuss why the applicant needed to receive special exception to be converted to a hospice residence home from the local board of zoning.

16. Section C, Economic Feasibility, Item 2 (Funding)

The letter from the applicant's CFO is noted. Please clarify if the $33,000 designated for start-up cost will come from the initial sale of shares in the corporation in the amount of $100,000.

The statement additional investors are ready to purchase shares in Life House, LLC in excess of $200,000 upon approval of the CON is noted. Please identify the additional investors and indicate the reason why there will be a need for additional investment. In addition, will this additional purchase of shares change the ownership structure of the LLC?

17. Section C, Economic Feasibility, Item 1 (Project Cost Chart)

The applicant has provided projects from 2007 to compare proposed project costs. Please compare the cost per square foot of construction to more recently similar approved projects such as CN0906-026A Hospice of Chattanooga, Inc. and CN0810-77A Hospice of Cumberland County d/b/a Cumberland House.

18. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Please explain why there are no contractual adjustments.

Please clarify if salaries and wages in the amount of $310,897 includes 24 hour nursing care.

Please clarify what the retirement of $250,000 in principal in Year Two represents.

Please specify the unit of measure for line A. Utilization Data. Please revise and resubmit the Projected Data Chart.

19. Section C, Economic Feasibility, Item 6.A

Please provide the proposed charge schedules for the proposal. Please also describe the anticipated revenue from the proposed project.

Please clarify if room and board will be reimbursed by Medicare. If not, how is room and board paid? Please clarify which HCPCS Codes (Q5001-Q5009) will be billed to Medicare.

20. Section C, Economic Feasibility, Item 6.B

The average daily charge schedule is noted. Please provide the certificate of need number for each project and date approved by the agency.

Since the applicant will be providing care to Medicare recipients, please compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code (s).

21. Section C, Economic Feasibility, Item 7

Please discuss the methodology used to come to the conclusion utilization of 50% will be sufficient to breakeven in Year One and a utilization rate of 82% will generate a significant positive cash flow in Year Two of the proposed project.

22. Section C, Economic Feasibility, Item 8

The statement "we have numerous investors ready to purchase shares of the corporation, once the CON is approved, which will give us ample operating capital if required" is noted. Please provide letters of capital commitment from those investors and documentation of the available funds.

23. Section C, Economic Feasibility, Item 9

Please discuss how medically indigent patients will be served by the proposed project.

24. Section C, Economic Feasibility, Item 10

The attached balance sheets located in Attachment C. from Clenton Daniels, CPA is noted. Please define the following categories totaling $628,050 as listed under "Revenue": Routine Rate $424,196; In Patient $175,854; Private Donations; $500; Memorial donations; $2,500 and Auxiliary Donations. If needed, please revise the Projected Data Chart under "B. Revenue from Services to patients" that will possibly more accurately categorize revenue.

Please clarify what Private, Memorial, and Auxiliary donations in the amount of $28,000 will be designated for. Also, are these donations recurring each year?

25. Section C, Economic Feasibility, Item 11

Please describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative. What were the alternatives considered prior to the building being completed and furnished?

26. Section C, Orderly Development, Item 1

Please be more specific in responding to this question. Please list the names of all existing health care providers (e.g. hospitals, nursing homes, home care organizations, hospice providers, etc.), managed care organization, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services. Responding to the question by stating the applicant will work with three medical centers and unknown home health and hospice care givers is not an adequate response.

27. Section C, Orderly Development, Item 3

The overall staffing chart is noted. The FTEs in the chart total 7.4 while the narrative response list 8.65 FTE employees, please clarify.

Please clarify if a chaplain, dietician or bereavement counselor will be employed. If not, how will these professionals be accessed by patients?

Please discuss the rationale of paying registered nurses and a social worker under the median wage as provided by the State of Tennessee Department of Labor and Workforce Development.

28. Section C, Orderly Development, Item 4

Please discuss the availability of registered nurses and a social worker while the applicant is planning to pay an hourly wage below the median hourly wage.

Please clarify if the facility is required to provide 24 hour nursing care. If so, was this considered in developing the expected staffing pattern of the proposed project?

What will be the shifts for medical staff?

Please indicate if a Medical Director has been identified. If so, please provide the name of the physician and documentation of his/her qualifications.

29. Section C, Orderly Development, Item 7

The applicant notes the facility will be accredited by the Community Health Accreditation Program (CHAP). Please describe CHAP.

Please indicate the total estimated accreditation cost (including application fees, yearly accreditation fees, site visit fees, etc.). Please clarify if the accreditation expense was accounted for in the projected data chart.

30. Project Completion Forecast Chart

The applicant has listed April 1, 2013 as the Agency projected Initial Decision date. The agency meeting for the month of April is scheduled for April 24, 2013. Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision to each phase of the completion forecast. Please adjust the Project Completion Forecast chart and resubmit.

Please clarify if the applicant is possibly too ambitious in initiating service in April 2013 since the applicant must be Medicare certified in order to render care to Medicare and TennCare patients.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Monday March 18, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

January 30, 2013

Connie Mitchell
Director/President
Life House, LLC
570 State Street
Cookeville, TN 38501

RE: Certificate of Need Application CN1301-001
Life House, LLC

Dear Ms. Mitchell,

This will acknowledge our January 29, 2013 receipt of your supplemental question response for a Certificate of Need for the establishment of a ten (10) bed residential hospice and the initiation of residential hospice services to be located at 570 State Street, Cookeville (Putnam County), TN 38501.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Thursday, January 31, 2013. If the supplemental information requested in this letter is not submitted by or before this time, consideration of this application may be delayed into a later review cycle.

---

1. **Please re-submit the first supplemental response by typing each question and the response underneath. This includes responses to the Project specific criteria for Residential Hospice Services included in *Tennessee's Health: Guidelines for Growth's.* If there is a table in a response, please include the source of data underneath.**

2. **Section B, Project Description, Item I.**

   Please clarify if it is a requirement of Medicare that you first need to be certified as a non-residential hospice or affiliated with a Medicare certified hospice to be eligible to apply

for certification by Medicare as a residential hospice? Please contact the Tennessee Department of Health and provide the results of your contact.

The applicant states in the supplemental response "our CNA number includes LPNs and the pay is comparable". Please clarify how a CNA's pay is comparable to an LPN.

3. **Section B, Project Description, Item IV. (floor plan)**

The revised floor plan labels are too small to read. Please provide a revised floor plan that "zooms in" enough so that the room labels are readable.

Please answer the following questions in narrative form;

- Please indicate the size of the patients rooms and if they will be private.
- Please indicate if all the restroom facilities will be full baths. Will two patient rooms share a restroom?
- Please indicate where the locations of the restroom facilities are for staff and visitors.

The attached floor plan is labeled "Cookeville Adult Living Facility and Hospice, Cookeville, TN". Please clarify if the applicant plans to also provide services under the Adult Living Facility license. If not, please submit a replacement floor plan that is correctly labeled. If the applicant is planning to be also licensed as an adult living facility please discuss licensure requirements such as a firewall to separate units and a fire door.

4. **Section B, Project Description, Item II A.**

The updated square footage and cost per square footage chart is noted. The applicant has noted the construction cost of $109,000 as the construction/renovation cost. Please clarify how this amount was calculated.

5. **Section C, Need Item 1**

The 5 Principles for Achieving Better Health responses are noted. Please clarify what the acronyms CAQH, CORE and UPD represent. What type of quality improvement program will the applicant adopt to continue to monitor and adhere to standards?

6. **Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Services**

Question 1: Residential Hospice Need formula.

- The bed need formula in attachment 6 is noted. Please break out the need formula by county.
- Please indicate if the data source for cancer deaths were from Tennessee Department of Health Cancer Registry. If not, please calculate the residential need formula using official cancer registry data from the Tennessee Department of Health. Please indicate the latest year of data used.
- The Residential Hospice Guidelines indicate all figures are rounded off to whole numbers. If this is the case, in column 1 of the attachment, should 7.06 be rounded to 7 rather than 8?

- Please explain in a narrative each column provided in Attachment- 6 Bed Need.

Question 2: Service Area

- Why are the service area counties selected reasonable to which the applicant intends to provide services?

Question 4 a.: Please state why the population and Hospice bed formula supports the need for a 10 bed residential hospice. Please do not reference other parts of the application in addressing this criterion.

Question 4 d.: Please provide how existing hospice providers and physicians will be expected to assist the residential hospice in referrals and coordination.

Question 5: The statement "we will give routine care and hospice care in-house or under contract with the home hospice providers" is noted. Please clarify this statement. How would the applicant sub-contract with other hospice providers? Does the applicant intend to apply for the certificate of need for in-home hospice services too?

Question 9: Please address this question by not referring to other parts of the application. Please clarify how the applicant will ensure the patient case mix shall be reasonably consistent with that of existing hospices in the service area and should not exclude hard-to-serve patients.

The statement "our patient mix, from preliminary indications, will be more the hard to serve that have been falling through the cracks under current services available" is noted. Please provide an example of a patient who has fallen through the cracks in the proposed service area and not received the appropriate hospice level of service. Please do not use patient identifying information in your response. Also, please provide a description of what the applicant defines as a "hard to serve" patient.

Question 11: Please list all items in this criterion and attest that the applicant will collect the requested data on an ongoing basis for accountability on program planning and monitoring budgetary priorities.

7. **Section C, Need, Item 6**

The provided table by clinical condition admission type for Year 1 is noted. It appears the applicant is projecting a majority of care will be provided to non-cancer patients in Year One. The applicant projects to provide care to 15 cancer patients and 20 non-cancer patients. Please clarify the methodology the applicant used to calculate these numbers. Also, how is the applicant in line with the hospice bed formula while the bed formula assumes other hospice users (non-cancer) is assumed to be 15% of the estimated cancer patients that utilize hospice services while the applicant projects 57% of patients in Year One will be non-cancer patients?

8. **Section C, Economic Feasibility, Item 6.A**

In the supplemental response, the applicant states room and board will be collected from patients. Collected room and board associated with the Residential Hospice is considered revenue. Please include the anticipated room and board charges in the projected data chart and submit a revised projected data chart.

The applicant has provided proposed charges compiled from the 2011 JAR of Tennessee Residential Hospices. Please clarify if these figures are before or after contractual adjustments. Please clarify how the applicant can use these figures while contractual adjustments in the projected data chart are unknown.

9. Section C, Economic Feasibility, Item 6.B

The provided FY2013 Hospice Payment Rates Before Wage Adjustment Table is noted. Please indicate if these are Medicare rates.

10. Section C, Economic Feasibility, Item 10

The attached balance sheets located in Attachment C. from Clenton Daniels, CPA is noted. Please define the following categories totaling $628,050 as listed under "Revenue": Routine Rate $424,196; In Patient $175,854.

Please clarify what Private, Memorial, and Auxiliary donations in the amount of $28,000 will be designated for. Also, are these donations recurring each year?

11. Section C, Orderly Development, Item 3

The budgeted amount of $8,000 for Meals and Food in Year One is noted. This calculates to $7.30 per meal for the patient census. What other funding sources will be used to support this budget item? Please clarify if this amount is under budgeted.

Please discuss the rationale of paying registered nurses and a social worker under the median wage as provided by the State of Tennessee Department of Labor and Workforce Development. Especially when the applicant states in the supplemental response" we are looking for physicians, PAs and RNs available in our area with hospice backgrounds".

12. Section C, Orderly Development, Item 7

The accreditation expense of $8,066.00 is noted. Please clarify if the accreditation expense was accounted for in the projected data chart. If not, please include in the projected data chart and resubmit the projected data chart.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Monday March 18, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted

with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

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Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

Copy

Supplemental #1

Life House, LLC

CN1301-001

SUPPLEMENTAL- # 1
January 29, 2013
10:20am

Life House, LLC.
570 State St., Cookeville, TN 38501

2013 JAN 29 AM 10 15

January 29, 2013

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
500 Deaderick Street
Suite 850
Nashville, TN 37243

RE: Certificate of Need Application CN1301-001

Dear Mr. Earhart,

This will acknowledge the receipt on January 21, 2013 of your request for supplemental information for clarification and discussion.

Please accept the following as my response to each section referred to in your correspondence.

---

1. Section A, Applicant Profile, Item 4

See attachment 1 - Articles of Organization

The existing ownership structure is of Life House, LLC is Constance Mitchell, President - 25%, Jack Mitchell, CFO- 25%, Richard Gerhart, Vice President - 25%, and Sylvia Gerhart, Secretary - 25%.
See attachment 2 - Ownership Organizational Chart.

The Other owners of the corporation are related as follows;
Jack Mitchell – husband
Richard Gerhart – Business associate
Sylvia Gerhart – Business associate (wife of Richard)

Completed above.

Life House, LLC. and the owners of Life House, LLC have no interest in any other health care facility.

2. Section A, Applicant Profile, Item 5

There is not currently a management/operating entity for the proposed project. The resumes of the four owners of Life House, LLC were intended to provide business background on the founding individuals and not hospice management acumen. The present directors will be expanded to include directors with legal, financial, medical, hospice and social work expertise as we near operational phase. The completed board will be responsible for choosing and over sight of a

medical director and administrator. We will surround ourselves, as business owners and for our residents, with the best professionals available to meet the needs of this facility and our residents.

3. Section A, Applicant Profile, Item 13

We have contacted UHC Community Plan, Amerigroup and TennCare about contracting and are in the application process. We need State of Tennessee Health Department licensure to complete the applications and are waiting on this CON to continue.

4. Section B, Project Description, Item 1

"LPN" is listed as a labor expense by DIA, CPA on page 78 because our consultation with Cumberland Hospice House suggested that higher patient numbers were more properly served by a mixture of LPN/CNA disciplines led by RN's as opposed to sole use of CNA's. Our CNA number includes LPNs and the pay is comparable.

Bereavement services will be offered for planning and conducting final services for patients and providing support for the patient's survivors for a period of one year beyond the death of their loved one. The services will be conducted in accordance with specific religious affiliations of the patient and appropriate clergy outside the residential hospice may be employed.

The hospice levels of care are routine hospice care, continuous hospice care, general inpatient care and respite inpatient.

The Residential Hospice is required to be licensed by the State to be reimbursed by Medicare.

Hospice care is the model for quality, compassionate care for people facing a life-limiting illness or injury. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. The belief in hospice care is that each of us has the right to die pain free and with dignity, and that our families will receive the necessary support to allow us to do so.

Hospice focuses on caring, not curing and many times is provided in the patient's home, when at home care givers are available. The other alternatives are hospital, nursing homes and free standing residential hospice facilities such as our proposed project. Residential Hospice offers a comfortable," homelike" setting with appropriate 24 hour care when that level of care is not available in the patient's own home. Hospice care is covered under Medicare, Medicaid and most private insurance plans and HMOs.

5. Section B, Project Description, Item IV. (floor plan)

See attachment 3 – floor plan

6. Section B, Project Description, Item II A.

See attachment 4 – Cost per square foot chart

7. Section B, Project Description, Item II C.

The residential hospice in Nashville is Alive with 30 resident beds and it showed occupancy of 80.5% in 2011. The Crossville location is Cumberland House with 6 beds and occupancy in 2011 of 63% and in Knoxville, Tennova (Mercy) is an 18 bed facility with occupancy of 83%. Only one patient with two days was reported by these facilities on their 2011 (reported in 2012) JAR report from our proposed service area.

8. Section B, Project Description, Item III.A.(plot plan)

See attachment 5 – plot plan

9. Section C, Need Item 1

Principal One: The purpose of the State Health Plan is to improve the health of Tennesseans.

Life House has a large role to play in the State Health plan to improve the health of Tennesseans. A review of our nine county area of Tennessee reveals that our service area population is 21.1% enrolled in Tenncare as opposed to 18.5% for the State of Tennessee as a whole. Our service area has a median age of 41.1 years as opposed to the State median age of 37.8 years, our service area median household income is 20% less than the state median income. Additionally, our service population suffers a 3% greater number of residents falling below the poverty level than the state averages. These figures all add up to a negative factor in the health care sector of below average incomes and above average aging population. To date our service area has no convenient accessibility to residential hospice care. Demographics, also, show that our service area is continuing to age faster than the state, indicating an influx of retirees who will, also, be in need of our services.

Principal Two: Every Citizen should have reasonable access to health care.

Reasonable access for our rural communities is not Nashville, Knoxville or a hospice out of your comfort area. It's where your family is or your local hospital is, and where your kids were born. It is where the family doctor is, where the pastor from your church is and where your life is. The trend is to have more residential hospice in more areas to comfort our citizens as they go from this home to the next. Localizing is reasonable to our citizens and reasonable to our professional services providers.

We are anticipating our service area demographics by being able to provide indigent care through our non-profit support corporation, Life House Friends, Inc.

Principal Three: The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.

Life House is somewhat unconventional but we are born out of necessity. This home has had three of my relatives live and die here with outside hospice care, coming to assist. How fortunate I am to have had the means and the health to take care of my loved ones. Many are not so fortunate. My goals are to share our experience and our home with others so their journey can be more fulfilling for them and their families. This is economically feasible and is meeting our community's needs, with great support from our friends, neighbors and health care community. This facility answers the need for all citizens to have reasonable access to health care and in this case, residential hospice care.

Principal Four: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

We are looking into the state of the art information systems including CAQH , CORE, UPD for universal data access and control as well as to adhere to all HIPPA guidelines for information security. Staff will be trained for information security on an annual basis in addition to when hiring.

Principal Five: The state should support the development, recruitment and retention of a sufficient and quality health care work force.

Our facility will utilize many of our under or unemployed mature health care professionals such as RNs, LPN's, and CNA's that want to continue to contribute but are left out of full time employment. Many retired professionals have offered to volunteer to help the folks in need. Our genre seems to include utilizing the strengths, talents and knowledge of our senior citizens that still have much to offer our health care community.

10. Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Service

1. The residential bed need formula was used in table 11 of the original CON and indicates the need for 10+ beds by 2017. **See attachment 6, Bed Need**

2. The service area is Putnam and the eight surrounding counties of Clay, DeKalb, Jackson, Macon, Overton, Pickett, Smith and White. The population is estimated to be 215317 in 2017.

3. There are no other residential hospices in the service area.

4 a. As stated, the population and the Hospice Bed Need Formula support the need for a 10 bed residential hospice.

b. The nine county geographic area is approximately 2815 square miles. The population of the service area is not serviced by a residential hospice, as supported by the 2012 JAR county data of patients served.

c. The distances the citizens of our nine county service area will travel for our services or to visit loved ones is 50 miles or less. Our furthest point is Macon, Clay and Pickett counties and they are within the 50 mile radius. Many of the residents are familiar with the Cookeville area as their city

to shop, seek medical assistance or recreation, with theaters and restaurants. Located half way between Nashville and Knoxville, Cookeville is the closest city for services for most of our service area residents.

d. The existing services that are available are the Cookeville Regional Medical Center, Livingston hospital, three area Home Hospice providers, area physicians including a VA clinic and nursing homes that are many times too full to accept the hospice patients. The social workers at the hospitals are anxious to have our services available as an additional option for their sometimes difficult-to-place people. The same is true for the home hospice providers we have spoken with about our services. It seems we are filling a much needed gap in services in our communities.

5. The service we provide is in addition to and coordinated with the other hospice providers to give patients choices that do not currently exist in our service area. We will give routine care and hospice care in-house or under contract with the home hospice providers.

6. We have established Life House Friends, Inc which is a non-profit corporation. The purpose of Life house Friends is to raise funds to assist hospice residents that need additional financial support and to help educate the communities, both residents and medical providers, about hospice services. Life House Friends, Inc has entered into a contract with Synergy to aid in our efforts to build and sustain funds to support our patients. The Gerharts have extensive background in both fund raising and in building volunteer groups to carry out mission activities.

7. Life House friends will, in conjunction with Life House, hold educational seminars through the volunteers with hospice background. The passion with our volunteers is overwhelming and contagious. We will be continuing to hold tours of the facility and be speaking at events, seminars and professional meetings to educate the medical professionals about the need and genuine service provided to end-of-life patients by residential hospice providers.

8. The ability to pay is not inhibiting our ability or willingness to provide services. The nonprofit support and our desire to serve all who have the need will be our guiding force. Life House, LLC and Life House Friends were born through the coming together of professional individuals of three large area Methodist churches, a Catholic church, a Morman congregation and a three thousand plus member Charismatic Fundamental church of our area. Our associates are mission motivated.

9. Our patient mix, from preliminary indications, will be more of the hard to serve that have been "falling through the cracks" under current services available. See, also, our comments in question 9 principal one regarding the particular difference of our service population from the state population figures.

10. We will work with the homeless shelters, churches and other civic organizations to insure that all with need will have our residential hospice services available to them.

11. All required data for the annual JAR, program planning and budgeting will be collected and compiled on an ongoing basis for accountability to the governing agencies and our director/shareholders.

11. Section C, Need, Item 3
See attachment 7, State of Tennessee County Service area map

12. Section C, Need, Item 4.A.
See attachment 8, County Data requested

13. Section C, Need, Item 4.B.

The residents of our proposed service have lower median household incomes than the State average, 20% have incomes below the poverty level and 21% are TennCare recipients. We will be contacting other service providers in our service area to offer our services to their patients, as well as, helping the residents apply for program such as Choices that are available to them.

Upper Cumberland Human Resources Agency (UCHRA) provides services to our entire proposed service area. These services include transportation services that are handicap accessible. We can arrange transportation through them for our patient's families. I have worked with them in the past and will make available their many other service to our residents and their families.

14. Section C, Need, Item 6
See attachment 9, Requested Tables 1 and 2

!5. Section C, Economic Feasibility, Item 1

According to Fema this designation means moderate to low risk areas with hazard limits between 100 and 500 year flood plain. Notice the box checked was "no" as to Fema special flood hazard zone. **See Attachment 10, Definitions Fema Flood Zone Designations**

There was no provision in the zoning code in Putnam County for Residential Hospice when we initially inquired about the use. The code was created and we, then, applied for the exception created for RS-10 zoning allowing residential hospice.

16. Section C, Economic Feasibility, Item 2 (funding)

The initial sale of shares is where the $33000 was generated.

The additional investors are family members that share our calling and passion for this project. This sale may only be necessary to fund any delayed cash flow reimbursements through Medicare and TennCare. We understand that as a new provider delays are routine. Should a sale occur there will be no change in ownership over 4% and the current ownership will retain the majority shares.

17. Section C Economic Feasibility, Item 1 (Project Cost Chart)

The cost per square foot for the new Cumberland House CN0810-77A was $134.08 for new construction and CN0810-77A Hospice of Chattanooga, Inc. the project per square foot cost was $388.36 for 16740 square feet of space. Our remodel cost has been only $24.49 per square foot and with our acquisition cost of $45000 for our 4450 square foot facility of $101.13 per square foot, gives us a total cost per square foot of $125.62 for our 10 bed facility..

18. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

We have no existing contracts at this time and no data to support adjustments.

The salary and wages figure of $310,897 does include 24 hour nursing care.

The $250000 of principal in year two represents the plan to exercise the option to purchase the property in year two.

See Attachment 11, Projected Data Chart

19. Section C, Economic Feasibility, Item 6.A

The proposed charge schedule is as follows for 2013:

Service	Patient Days	Rate	Revenue
Routine Care	615	$132	$ 81,180
General Inpatient	870	$593	$515,910
Respite Care	15	$141	$ 2960
Total	1500	$400 Av w/o charity	$600,050

Numbers compiled from 2011 JAR of Tn. Residential Hospices

Room and Board is not going to be paid by Medicare and will be provided by the families or our charity foundation. Room and board is not included in our projected revenue numbers. The HCPCS code Q 5006, patient care provided in an inpatient hospice facility will be billed to Medicare.

20. Section C, Economic Feasibility, Item 6.B

Facility	CON number	Date Approved	Average Daily Charge w/charity 2011
Life House	Pending	---	$418 projected
Cumberland House	CN0810-77A	2010	$279
Hospice of Chattanooga	CN0906-26A	2011	$599
Residence at Alive	CN9612-074A	1997	$501
Wellmont	CN9312-062A	1994	$243

The average daily charge for the four active residential hospices combined is the combined revenue of $7,710,401 divided by the combined number of patient days which is an average charge per patient day of $469. Life House is projecting charges slightly less than the average.

FY2013HospicePaymentRatesBeforeWageAdjustment

Code	Description	Rate	Life House Rate	
651	Routine Home Care	$153.45	$132.00	
652	Continuous Home Care Full Rate = 24 Hours of Care $37.32 = Hourly Rate	$895.56	0	
655	Inpatient Respite Care	$158.72	141.00	
656	General Inpatient Care	$682.59	$593.00	

21. Section C, Economic Feasibility, Item 7

Based on the average revenue per patient day, as reviewed above of the four existing residential hospices, and our anticipated expenses for Life House, we came to our conclusions on profitability. The charitable contributions do not exceed our net operating income and we would remain profitable with our projected bad debt and indigents. **See attachment 11, Revised Projected Data Chart**

22. Section C, Economic Feasibility, Item 8

Our prospective investors are family members and friends who have express willingness to invest should the need arise. We have not sought letters of commitment or proof of funds pending the approval of the CON.

Life House Friends, Inc and Life House, LLC are applying for profit and non-profit grants through Synergy Funding Services and will continue to apply for grants and donations.

23. Section C, Economic Feasibility, Item 9

We have Life House Friends, Inc which is a nonprofit 501c3 corporation. This corporation has been formed specifically for raising funds to take care of indigent patients and to help care for the special needs of our end-of-life patients.

24. Section C, Economic Feasibility, Item 10
See attachment 11, Revised Projected Data Chart

The Private donations are from people that individually wish to contribute to the hospice. Memorial donations are from the relatives of the deceased patients. Auxiliary contributions are from our foundation, Life House Friends, Inc that conduct fund raising activities to support our indigent patients and other patient needs.

25. Section C, Economic Feasibility, Item 11

Both the Mitchells and the Gerharts have incurred personal family hospice needs and have witnessed the needs of area residents and church needs for residential hospice services. These needs were ultimately resolved through travel to distant places or with the help of local home health or volunteers at great expense and effort. We looked for reasonable alternatives and found only in-home hospice care in our immediate area. As we spoke with area social workers at CRMC, Caris In-Home Hospice, NHC Home Health and the NHC nursing home we found there to be a group of patients, with no one to care for them in their homes, to be in need of another choice of a place to receive the care they need. Many times the nursing homes are unable to accommodate the short term hospice patient and there is not any other local alternative.

The Gerharts were exploring land purchase and new construction and the Mitchells, no longer needing the huge home for elderly parents, joined forces and the Life House project was born. After consulting with Michael Brady Architects, we were convinced that the former group home on State St in Cookeville was our most functional, most economical and swiftest answer to the residential hospice need in our community.

When we contacted the planning and zoning department in Cookeville, James Mills, the director, was delighted and felt that the use for this property was the highest and best use of the property and wrote their new zoning code accordingly.

We consulted with Ken Taylor from Cumberland House and he was very optimistic about our project and the need in our service area. He gave us many insights into the challenges of our undertaking. He continues to be very encouraging and supportive.

26. Section C, Orderly Development, Item 1

Since our Letter of Intent has been published, we have initiated the phase of our plan of contacting and interacting with the local medical community. Through personal contact and a series of open houses we have contacted the following organizations to discuss contracting and referrals:

Cookeville Regional Medical Center, Livingston hospital, Caris Home Health, Gentiva Home Health, Avalon Home Health and Quality Home Health. We have spoken with many individual social workers from these organizations, medical doctors and other professionals and have met with "we have needed this service for a very long time." They are all excited to have residential hospice as a care option and have said they will refer qualified patients to our facility.

27. Section C, Orderly Development, Item 3

The FTE 7.4 came from the chart providing salary comparisons of the staff providing patient care. The FTE 8.65 includes non patient care giving staff such as clerical, administrative and bookkeeping and is the total staffing for the facility .

We will have chaplain, dietician and bereavement counseling service available to our patients and their families. Richard Gerhart, holds an MA degree from Asbury Seminary in World Missions and

Evangelism which contained bereavement counseling, and he is an ordained minister of the Wesleyan Church. He is a member of the Overton County Ministerial Association. Clergy from other ministries will be contacted as needed for individual patient preference. A dietician and dietary needs will be handled through an outside vendor and was included in our budget under Patient Expenses meals and food. Year one, we budgeted $8000 and year two, $16000.

We have the availability of many retired professionals including RNs, LPNs, CNAs, social workers and other workers including maintenance and grounds keeping. These folks have great skills and experience, want to make a little extra income and mostly want to be involved with and giving back to their communities. According to the Tennessee Department of Labor and Workforce in the program Senior Community Service Development Program (SCSEP), "Many Tennessee employers are hiring older workers as part of their recruitment efforts to use their skills, experience and talents they possess". Being four retirees ourselves, I think we can relate! **See Attachment 12, SCSEP information**

28. Section C, Orderly Development, Item 4

According to the SCSEP they pay in their program minimum wage of $7.25 per hour. We have volunteers as well that have offered services for the privilege of serving. Our support community is strong, we will meet our staffing numbers and figures.

The facility will have 24 hour nursing staff available. Mrs. Gerhart is a Registered nurse and will be working in that capacity at the facility. She will oversee the nursing staff to insure excellent quality of care. Her shifts will be added to the nursing staff numbers for our 24 hour coverage.

Shifts of medical staff will be basically three shifts per day anticipated at 7-3, 3-11, and 11-7. It is planned that all fulltime employees will be scheduled on these shifts in order to develop consistent team work. Coverage of absences and downtime will be minimal as all the owners will be at least CNA certified, with one an RN and one a nursing home administrator.

The Medical Director has not been identified. We are looking at the Physicians, PAs and RNs available in our area with hospice backgrounds. Once we are approved our expanded board will make the final decision.

29. Section C, Orderly Development, Item 7

Community Health Accreditation Program (CHAP) is an independent, not-for-profit, accrediting body for community-based health care organizations. Created in 1965, CHAP was the first to recognize the need and the value for accreditation in community-based care. CHAP is the oldest national, community-based accrediting body with more than 5000 agencies accredited nationwide.

The Initial application has been submitted but the process is lengthy and not completed at a point in time until all of our licensing, approvals with Medicare etc, and facility inspections have been completed. This will take long enough that it is not a budget item at this time.

The fee to initiate the application is $500, there are 3 site visits at a total cost of $2985, a three year accreditation fee of $4581 for a total cost from beginning to accreditation of $8066. This is our long term goal and we will work to accomplish it within the first three years.

We are joining the National Hospice and Palliative Care Organization, fee $555, and the Tennessee Hospice Organization, fee $300, once we are approved and licensed. These fees are in our marketing budget.

30. Project Completion Forecast Chart

The Project Completion Forecast Chart has been adjusted to reflect the April 24 date and the 30 day time to become State licensed and for the Medicare/TennCare processing time of 6 weeks. Our opening as a residential hospice, fully licensed and functional has been changed to July 1, 2013. Perhaps we were too ambitious and need to practice the virtue of patience (usually not an entrepreneurial attribute)!!! **See attachment 13, Revised Project Completion Forecast Chart**

Attachment 1, Articles of Organization

SUPPLEMENTAL- # 1

January 29, 2013
10:20am

Business Entity Detail

Entity details cannot be edited. This detail reflects the current state of the filing in the system.

Return to the Business Information Search.

Actions Available For This Entity:

File Annual Report | Update Mailing Address
Certificate of Existence | Change Registered Agent

000656664: Limited Liability Company - Domestic

Printer Friendly Version

Name: LIFE HOUSE, LLC
Old Name: AUTHOR DIRECT MARKETING, LLC

Status: Active
Formed in: TENNESSEE
Fiscal Year Close: December
Term of Duration: Perpetual
Principal Office: 570 STATE ST
COOKEVILLE, TN 38501-3718 USA
Mailing Address: 570 STATE ST
COOKEVILLE, TN 38501-3718 USA
AR Exempt: No
Managed By: Member Managed

Initial Filing Date: 04/15/2011
Delayed Effective Date:
AR Due Date: 04/01/2013
Inactive Date:
Obligated Member Entity: No
Number of Members: 4

Assumed Names | History | Registered Agent

Name	Status	Expires
No Assumed Names Found...		

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays

Attachment 2, Ownership Organization Chart

Life House, LLC
Ownership Organizational Chart

Attachment 3, Floor Plan

SUPPLEMENTAL- # 1
January 29, 2013
10:20am

COOKEVILLE ADULT LIVING FACILITY AND HOSPICE, COOKEVILLE TENNES

REVISED

MBI
michael brady inc.
architecture.engineering.interiors.

MBI PROJECT #120393

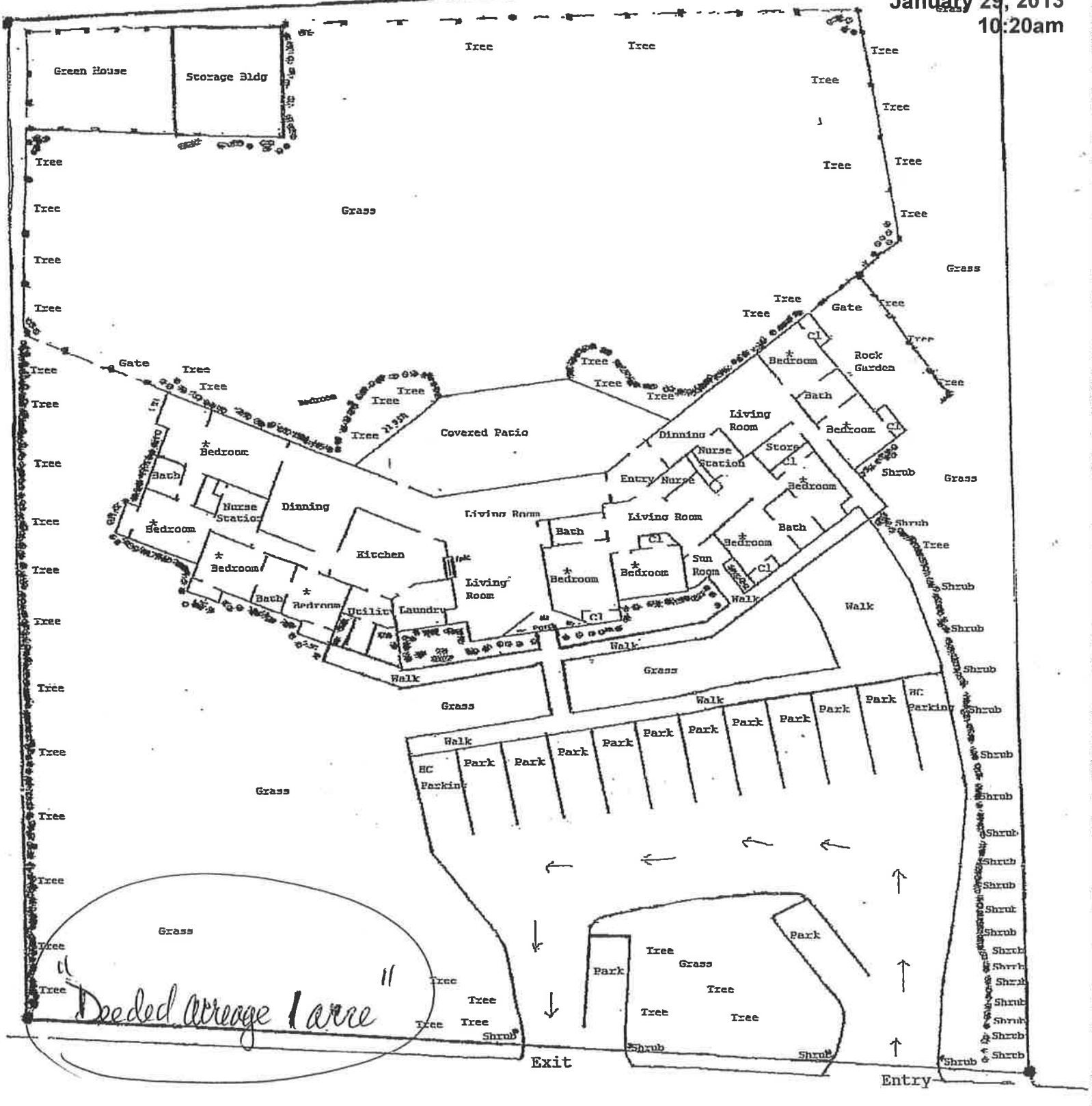
Attachment 4, Revised Cost per Square Foot

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
					4450		4450	109000		109000
B. Unit/Depart. GSF Sub-Total					4450		4450			
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF					4450		4450	$24.49		$24.49

Attachment 5, Revised Plot Plan – 1 Acre

SUPPLEMENTAL - # 1
January 29, 2013
10:20am



570 State St Site Plan Life House Hospice

Connie Mitchell 881-6417

Richard Gerhart 644-1785

21

— 6' Wood Privacy Fence

— Property Line

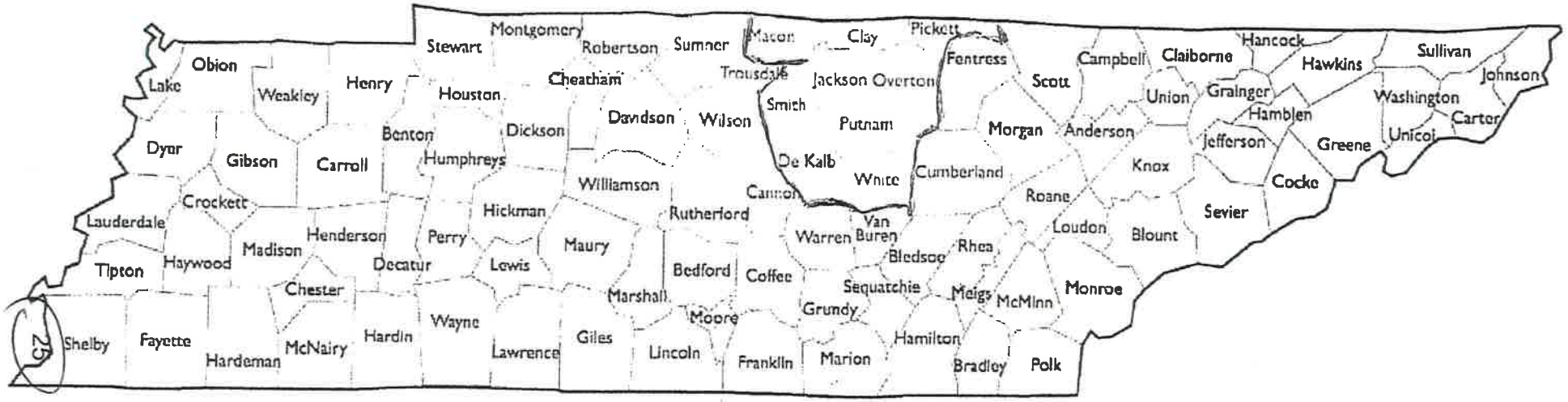
Attachment 6, Bed Need

The Tennessee Residential Hospice Bed Need Formula reflects the following need based on the preceding cancer statistics.

Bed Need

Non-cancer hospice usage	2010 15%	2010 55.6%	2017 15%	*2017 55.6%*
Cancer Deaths	493	493	528	***528***
Patient Hospice utilization 40%	198	198	212	***212***
Other users 15 and 55.6%	30	111	32	***119***
Total Hospice Users	228	309	244	***331***
Total hospice days = Users x average stay 45 days	10260	13905	10980	***14895***
Average daily hospice census = Total days divided by 365	29	39	31	***41***
20% average daily census (adc)	5.8 = 6	7.8 = 8	6.2=7	***8.2 = 9***
Bed need = adc divided by .85 occupancy	7.06	9.41	7.29	***10.59***
Bed Need	8	10	8	***11***

Attachment 7, State of Tennessee Revised Service Area Map



State of Tennessee

Attachment 7, Service Area Map

SUPPLEMENTAL- # 1
January 29, 2013
10:20am

Attachment 8, Population Data Chart Requested

12. Attachment 8

Variable	Clay	DeKalb	Jackson	Macon	Overton	Pickett	Putnam	Smith	White	ServiceArea	Tennessee
2012(CY) Age 65+	1464	2914	1995	3083	3765	1101	11184	2636	4354	32496	878496
2013(PY) Age 65+	1500	2978	2061	3167	3850	1130	11542	2708	4467	33403	904587
Age 65+ %change	.98	.97	3.0	1.5	.30	2.6	3.2	2.7	2.6	2.8	3.0
Age 65+ %Total(PY)	18	15	18	13.5	18	22	15.8	13.3	17.4	16	14
2012 Total population	8201	19366	11419	23208	21377	5069	72489	20104	25521	206754	6,361,070
2013 Total population	8225	19529	11503	23452	21467	5107	73212	20330	25711	208536	6,414,297
Total Pop % change	0.3	1.0	1.0	1.0	0.4	0.7	1.0	1.1	0.7	0.9	0.8
TennCare Enrollees	1992	4354	2592	5796	4427	990	14258	3813	5796	44018	1,206,538
TennCare Enrollees %total pop	24.2	22.2	22.5	24.7	20.6	19.3	19.4	18.7	22.5	21.1	18.5
Median age years	46.0	40.2	44.1	37.5	41.7	44.5	35.9	39.2	41.1	39.1	37.8
Median Household Income $	28682	36870	32846	34747	34108	31157	34305	43580	34642	35130	43989
Population % below Poverty Level	20.0	18.5	22.9	23.9	19.8	16.3	24.9	17.2	20.8	20.0	16.9

Attachment 9, Requested Data Charts 1 & 2

Attachment 9

Table 1

Year	Admissions	Patient days	Average Daily Census	Average Length of Stay	Facility Occupancy
Year 1	34	1500	4	45 days	40%
Year 2	67	3000	8	45 days	80%

Table 2

Disease Classification	55 and younger	56-65	66-84	85 & older
Cancer	2	2	7	4
Heart Disease	1	1	3	2
General Debility				1
Dementia				
Lung Disease	1		2	
Stroke		1	2	1
Kidney Disease		1		1
Other			2	
Total	4	5	16	9

Attachment 10, Fema Information, flood plains

FEMA Map Service Center

Definitions of FEMA Flood Zone Designations

Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.

Moderate to Low Risk Areas

In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:

ZONE	DESCRIPTION
B and X (shaded)	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.
C and X (unshaded)	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.

High Risk Areas

In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all of these zones:

ZONE	DESCRIPTION
A	Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones.
AE	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30 Zones.
A1-30	These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format).

Attachment 11, Revised Projected Data Chart

SUPPLEMENTAL- # 1
January 29, 2013
10:20am

2013 JAN 17 AM 10:17

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

		Year 2013	Year 2014
A.	Utilization Data (Specify unit of measure)Bed Days	1500	3000
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 515910	$1056166
2.	Routine	81180	167021
3.	Respite	2960	4913
4.	Other Operating Revenue (Specify)_Donations	28000	28000
	Gross Operating Revenue	**$ 628050**	**$ 1256100**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$	$
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 11984**	**$ 23160**
NET OPERATING REVENUE		**$ 616066**	**$ 1232940**
D.	Operating Expenses		
1.	Salaries and Wages	$ 310897	$ 379769
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	40000	75000
4.	Taxes	0	0
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list)	$ 110400	143382
	Total Operating Expenses	**$ 541297**	**$ 693151**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 74769**	**$ 539789**
F.	Capital Expenditures		
1.	Retirement of Principal	$	$ 250000
2.	Interest		
	Total Capital Expenditures	**$**	**$**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 74769**	**$ 289789**

Attachment 12, Senior Community Service Employment Program (SCSEP) Data

Senior Community Service Employment Program (SCSEP)

SUPPLEMENTAL- # 1
January 29, 2013

The Senior Community Service Employment Program is an employment training program for low-income, unemployed individuals aged 55 years and older. The program provides subsidized, part-time work experience for a limited time through community service to obtain the skills necessary for permanent employment. Participants in the program learn new skills and talents, or enhance existing ones, through valuable work experience and other training to become competitive in today's workforce.

The Senior Community Service Employment Program is funded under Title V of the Older Americans Act. It is administered by the TN Department of Labor and Workforce Development through area agencies on aging and various other non-profit organizations.

PY 08 Senior Employment Service Coordination Plan (http://www.tn.gov/labor-wfd/scplan_july08.pdf)
(../SESC/index.htm)

(Click here (http://www.tn.gov/labor-wfd/TN_State_Integrated_Plan_2012.pdf)to view the 2012 State Integrated Plan. SCSEP Plan begins on pg. 94)

What Do Most Individuals Want?
-Receive an income
-Develop new skills
-Feel useful and needed
-Make new friends and stay in touch with the world
-Have a sense of achievement and accomplishment
-Know that he or she is a valuable asset to the community

Older Workers Are Good for Business
The assets of older workers are increasingly being recognized by employers. Those assets include a strong work ethic, high productivity, extensive life and work experience, and low absenteeism and turnover rates. Many Tennessee employers are hiring older workers as part of their recruitment efforts to use the skills, experience, and talents they possess.

Who Is Eligible?
Individuals applying for the Senior Community Service Employment Program must meet specific requirements in order to be eligible:

- A legal resident of Tennessee
- 55 years of age and older
- Unemployed
- A family income at no more than 125% of the federal poverty level

Senior Community Service Employment Program participants receive an assessment to determine individual needs for training, supportive services, and potential for employment. Eligible participants are closely matched with their personal goals and placed in a position in community service (nonprofit, public, or private sector) for approximately 20 hours per week. Participants receive the federal minimum wage of $7.25 per hour. Other job-related training may consist of upgrading existing skills, developing new skills, limited educational opportunities, job counseling, and assistance in finding and keeping a job.

To gain work experience, Senior Community Service Employment Program participants are often placed in schools, hospitals, economic development iniative, weatherization activities, law offices, conservation programs, and many other sites. These sites translate into positions such as nurse's aides and teacher's aides, library clerks, clerical workers, adult and child day care assistants, campground recreational coordinators, maintenance workers, and many more occupations.

How Do I Apply?
To determine whether you are eligible for the Senior Community Service Employment Program, call the agency in your county and ask to speak with the "SCSEP Program Coordinator," who will do a brief "Question and Answer" evaluation over the phone to determine whether you qualify.

Click here to locate a SCSEP program near you (SCSEPContactList.shtml)

Reports, Plans, and Policies (SCSEPDocumenation.shtml)

Sub-grantees, Handbook

(SCSEPsubgrantees.shtml)

For additional information about the SCSEP program or to send comments, please contact:

TN Department of Labor and Workforce Development
Simi Atolagbe, Grants Program Manager
Senior Community Service Employment Program
220 French Landing Drive, 4B
Nashville,TN 37243
Phone: (615) 253-5869
Fax: (615) 741-3003

SUPPLEMENTAL- # 1
January 29, 2013
10:20am

AFFIDAVIT

2013 JAN 29 AM 10 17

STATE OF TENNESSEE

COUNTY OF Putnam

NAME OF FACILITY: Life House, LLC.

I, Connie Mitchell, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

TONYA J. REEDER
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF PUTNAM

Connie Mitchell, Pres / Director
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 29th day of January, 2013, witness my hand at office in the County of Putnam, State of Tennessee.

Tonya Reeder
NOTARY PUBLIC

My commission expires 4-24, 2015.

HF-0043

Revised 7/02

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

February 15, 2013

Connie Mitchell
Director/President
Life House, LLC
570 State Street
Cookeville, TN 38501

RE: Certificate of Need Application CN1301-001
Life House, LLC

Dear Ms. Mitchell,

This will acknowledge our January 31, 2013 receipt of your supplemental question response for a Certificate of Need for the establishment of a ten (10) bed residential hospice to be located at 570 State Street, Cookeville (Putnam County), TN 38501.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Thursday, February 21, 2013. If the supplemental information requested in this letter is not submitted by or before this time, consideration of this application may be delayed into a later review cycle.

---

1. **Section B, Project Description, Item I.**

   After discussions with various entities regarding the eligibility of receiving certification and receiving reimbursement from TennCare and Medicare, the applicant has three (3) options:

   1) Resubmit volume and revenue information that excludes Medicare and TennCare projections,

2) Include signed and dated documentation from an authority at Medicare, TennCare, and/or the Tennessee Department of Health stating very clearly that licensed only as a residential hospice, Life House, LLC will be eligible for certification and thus reimbursement by Medicare and TennCare for hospice services provided

or

3) withdraw the application.

2. **Section B, Project Description, Item I.**

The response to placing CNA's and LPNs in the same category using a median wage of $12.00 is noted. Please describe the pool and number of retired LPN's, RNs, and part-time social worker that will be willing to accept a below median wage.

3. **Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Services**

The Residential Hospice Need formula table is noted. The Residential Hospice Criteria states "Cancer death statistics to be used are from the most recent year" for the Tennessee Residential Bed Need formula. Please clarify the reason why the cancer deaths for each county was taken from 2017 cancer deaths column as listed in revised table 10 on page 5 of the #2 supplemental response.

There appears to be an error in the table for step B in the Tennessee Residential Bed Need Formula submitted in supplemental #2. In addition, the applicant used 2017 population projections. Please complete the following table only using the most recent cancer registry information.

County	Cancer Deaths	A. 40% x cancer deaths in co.	B. 15% x estimated cancer patients	C. A+B= Total hospice patients	D. C x 45 days= total hospice days	E. D/365=average daily census	F. 20% x E/.85

Please explain the reason the applicant used a 55.6% utilization rate for other hospice and projected bed need in the table on page 6 of supplemental #2 while this calculation is not included in the residential bed need formula?

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Monday March 18, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF _____

NAME OF FACILITY: _____

I, _____, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

_____
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the _____ day of _____, 20___, witness my hand at office in the County of _____, State of Tennessee.

_____
NOTARY PUBLIC

My commission expires _____, _____.

HF-0043

Revised 7/02

ORIGINAL-
ADDITIONAL
INFO.

SUPPLEMENTAL-3

Life House, LLC

CN1301-001

REVISED PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

		Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure)Bed Days	2500	3300
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 341295	$ 450509
2.	Routine	306900	405108
3.	Respite	0	0
4.	Other Operating Revenue (Specify)Donations/ room and board	99984	130360
	Gross Operating Revenue	**$ 748179**	**$ 985977**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 24000	$ 36000
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 35984**	**$ 59160**
NET OPERATING REVENUE		**$ 712195**	**$ 926817**
D.	Operating Expenses		
1.	Salaries and Wages	$ 279897	$ 379768
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	25000	35000
4.	Billing fees	46000	60000
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list) *_____	$ 87941	113382
	Total Operating Expenses	**$ 518838**	**$ 683150**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 193357**	**$ 243667**
F.	Capital Expenditures		
1.	Retirement of Principal	$100000	$ 100000
2.	Interest		
	Total Capital Expenditures	**$ 100000**	**$ 100000**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 93357**	**$ 143667**

AFFIDAVIT

2013 FEB 27 AM 11:49

STATE OF TENNESSEE

COUNTY OF Putnam

NAME OF FACILITY: Life House, LLC.

I, Constance J. Mitchell, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Constance J. Mitchell
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27th day of Feb, 2013 witness my hand at office in the County of Putnam, State of Tennessee.

Sylvia Gerhart
NOTARY PUBLIC

SYLVIA GERHART
STATE OF TENNESSEE NOTARY PUBLIC
OVERTON COUNTY

My commission expires March 15, 2016.

HF-0043

Revised 7/02

Copy

Supplemental #2

Life House, LLC

CN1301-001

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm

Life House, LLC.

570 State St., Cookeville, TN 38501

January 28, 2013

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
500 Deaderick Street
Suite 850
Nashville, TN 37243

RE: Certificate of Need Application CN1301-001

Dear Mr. Earhart,

This will acknowledge the receipt on January 21, 2013 of your request for supplemental information for clarification and discussion.

Please accept the following as my response to each section referred to in your correspondence.

---

1. Section A, Applicant Profile, Item 4

The applicant facility's corporate charter is noted. Please submit documentation from the Tennessee Secretary of State that acknowledges and verifies the type of ownership as identified by the applicant.

Response: See attachment 1 - Articles of Organization

Please describe the existing or proposed ownership structure of the applicant including an ownership structure organizational chart.

Response
The existing ownership structure is of Life House, LLC is Constance Mitchell, President - 25%, Jack Mitchell, CFO- 25%, Richard Gerhart, Vice President - 25%, and Sylvia Gerhart, Secretary - 25%. **See attachment 2 - Ownership Organizational Chart.**

Please explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant.

Response:
The other owners of the corporation are related as follows;
Jack Mitchell – husband
Richard Gerhart – Business associate
Sylvia Gerhart – Business associate (wife of Richard)

As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more interest.

Response:
Completed above.

Please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, 68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

Response
Life House, LLC. and the owners of Life House, LLC have no interest in any other health care facility.

2. Section A, Applicant Profile, Item 5
The applicant has indicated there will not be a management/operating entity for the proposed project. The applicant has provided the resumes of the four (4) directors of Life House, LLC. The four (4) resumes provided appear to not have any experience listed in residential hospice services. Please describe the applicant's experience in providing management services for residential hospice services.

Response:
There is not currently a management/operating entity for the proposed project. The resumes of the four owners of Life House, LLC were intended to provide business background on the founding individuals and not hospice management acumen. The present directors will be expanded to include directors with legal, financial, medical, hospice and social work expertise as we near operational phase. The completed board will be responsible for choosing and over sight of a medical director and administrator. We will surround ourselves, as business owners and for our residents, with the best professionals available to meet the needs of this facility and our residents.

3. Section A, Applicant Profile, Item 13

Please clarify if the applicant has contacted UHC Community Plan, AmeriGroup or TennCare Select regarding possibly contracting for Residential Hospice Services.

Response:

We have contacted UHC Community Plan, Amerigroup and TennCare about contracting and are in the application process. We need State of Tennessee Health Department licensure to complete the applications and are waiting on this CON to continue.

4. Section B, Project Description, Item 1

The applicant notes 3.15 registered nurse FTEs in the Project Description. Please clarify why "LPN" is listed as a labor expense by DIA, Certified Public Accountants on page 78 of the application.

Response:

"LPN" is listed as a labor expense by DIA, CPA on page 78 because our consultation with Cumberland Hospice House suggested that higher patient numbers were more properly served by a mixture of LPN/CNA disciplines led by RN's as opposed to sole use of CNA's. Our CNA number includes LPNs and the pay is comparable.

Please describe the bereavement services that will be offered.

Response:

Bereavement services will be offered for planning and conducting final services for patients and providing support for the patient's survivors for a period of one year beyond the death of their loved one. The services will be conducted in accordance with specific religious affiliations of the patient and appropriate clergy outside the residential hospice may be employed.

Please describe the hospice levels of care.

Response:

The hospice levels of care are routine hospice care, continuous hospice care, general inpatient care and respite inpatient.

Please clarify if the applicant is required to be a certified hospice, or affiliated with a Medicare certified hospice, to receive Medicare reimbursement for Residential Hospice Services.

Response:

The Residential Hospice is required to be licensed by the State to be reimbursed by Medicare.

Please define Residential Hospice Care

Response:
Hospice care is the model for quality, compassionate care for people facing a life-limiting illness or injury. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. The belief in hospice care is that each of us has the right to die pain free and with dignity, and that our families will receive the necessary support to allow us to do so.

Hospice focuses on caring, not curing and many times is provided in the patient's home, when at home care givers are available. The other alternatives are hospital, nursing homes and free standing residential hospice facilities such as our proposed project. Residential Hospice offers a comfortable," homelike" setting with appropriate 24 hour care when that level of care is not available in the patient's own home. Hospice care is covered under Medicare, Medicaid and most private insurance plans and HMOs.

5. Section B, Project Description, Item IV. (floor plan)
Please provide a revised floor plan that "zooms in" enough so that the room labels are readable.

Response:
See attachment 3 – floor plan

Please indicate the size of the patients rooms and if they will be private.

Response:
All rooms are 100 square feet or more and all will be private.

Please indicate if all the restroom facilities will be full baths. Will two patient rooms share a restroom?

Response:
All patient restrooms will be full baths and will be share by two residents.

Please indicate where the locations of the restroom facilities are for staff and visitors.

Response: A staff/visitors handicapped restroom facility is located adjacent to the main nurse station. This restroom does not have a shower.

6. Section B, Project Description, Item II A.
The applicant has stated patients and their families must travel to Crossville, Knoxville, or Nashville to access residential hospice services. Please list the Hospice Providers the applicant is referencing and their licensed occupancy rates for 2011.

The residential hospice in Nashville is Alive with 30 resident beds and it showed occupancy of 80.5% in 2011. The Crossville location is Cumberland House with 6 beds and occupancy in 2011 of 63% and in Knoxville, Tennova (Mercy) is an 18 bed facility with occupancy of 83%. Only one patient with two days was reported by these facilities on their 2011 (reported in 2012) JAR report from our proposed service area. The provided square footage and cost per square forage chart is noted. The applicant has placed the total project cost ($600,000) as the construction/renovation cost. Please resubmit the chart that reflects only actual renovation/construction cost and recalculate the Proposed Final Cost/SF.
See attachment 4 – Cost per square foot chart

7. Section B, Project Description, Item III A. Plot Plan

Please indicate the size of site (in acres) on the plot plan and re-sub

Response:
See attachment 5 – plot plan

8. Section C, Need Item 1
Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Please list the principles and provide a response to each.

Response:

Principal One: The purpose of the State Health Plan is to improve the health of Tennesseans.

Life House has a large role to play in the State Health plan to improve the health of Tennesseans. A review of our nine county area of Tennessee reveals that our service area population is 21.1% enrolled in Tenncare as opposed to 18.5% for the State of Tennessee as a whole. Our service area has a median age of 41.1 years as opposed to the State median age of 37.8 years, our service area median household income is 20% less than the state median income. Additionally, our service population suffers a 3% greater number of residents falling below the poverty level than the state averages. These figures all add up to a negative factor in the health care sector of below average incomes and above average

aging population. To date our service area has no convenient accessibility to residential hospice care. Demographics, also, show that our service area is continuing to age faster than the state, indicating an influx of retirees who will, also, be in need of our services.

Principal Two: Every Citizen should have reasonable access to health care.

Reasonable access for our rural communities is not Nashville, Knoxville or a hospice out of your comfort area. It's where your family is or your local hospital is, and where your kids were born. It is where the family doctor is, where the pastor from your church is and where your life is. The trend is to have more residential hospice in more areas to comfort our citizens as they go from this home to the next. Localizing is reasonable to our citizens and reasonable to our professional services providers.

We are anticipating our service area demographics by being able to provide indigent care through our non-profit support corporation, Life House Friends, Inc.

Principal Three: The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.

Life House is somewhat unconventional but we are born out of necessity. This home has had three of my relatives live and die here with outside hospice care, coming to assist. How fortunate I am to have had the means and the health to take care of my loved ones. Many are not so fortunate. My goals are to share our experience and our home with others so their journey can be more fulfilling for them and their families. This is economically feasible and is meeting our community's needs, with great support from our friends, neighbors and health care community. This facility answers the need for all citizens to have reasonable access to health care and in this case, residential hospice care.

Principal Four: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

We are looking into the state of the art information systems including CAQH , CORE, UPD for universal data access and control as well as to adhere to all HIPPA guidelines for information security. Staff will be trained for information security on an annual basis in addition to when hiring.

Principal Five: The state should support the development, recruitment and retention of a sufficient and quality health care work force.

Our facility will utilize many of our under or unemployed mature health care professionals such as RNs, LPN's, and CNA's that want to continue to contribute but are left out of full time employment. Many retired professionals have offered to volunteer to help the folks in need. Our genre seems to include utilizing the strengths, talents and knowledge of our senior citizens that still have much to offer our health care community.

9. Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Service
Please provide a response to each criterion and standard that are applicable to the proposed project (Residential Hospice Services).

Response:
1. The residential bed need formula was used in table 11 of the original CON and indicates the need for 10+ beds by 2017. **See attachment 6, Bed Need**

2. The service area is Putnam and the eight surrounding counties of Clay, DeKalb, Jackson, Macon, Overton, Pickett, Smith and White. The population is estimated to be 215317 in 2017.

3. There are no other residential hospices in the service area.

4 a. As stated, the population and the Hospice Bed Need Formula support the need for a 10 bed residential hospice.

b. The nine county geographic area is approximately 2815 square miles. The population of the service area is not serviced by a residential hospice, as supported by the 2012 JAR county data of patients served.

c. The distances the citizens of our nine county service area will travel for our services or to visit loved ones is 50 miles or less. Our furthest point is Macon, Clay and Pickett counties and they are within the 50 mile radius. Many of the residents are familiar with the Cookeville area as their city to shop, seek medical assistance or recreation, with theaters and restaurants. Located half way between Nashville and Knoxville, Cookeville is the closest city for services for most of our service area residents.

d. The existing services that are available are the Cookeville Regional Medical Center, Livingston hospital, three area Home Hospice providers, area physicians including a VA clinic and nursing homes that are many times too full to accept the hospice patients. The social workers at the hospitals are anxious to have our services available as an additional option for their sometimes difficult-to-place people. The same is true for the home hospice providers we have spoken with about our services. It seems we are filling a much needed gap in services in our communities.

5. The service we provide is in addition to and coordinated with the other hospice providers to give patients choices that do not currently exist in our service area. We will give routine care and hospice care in-house or under contract with the home hospice providers.

6. We have established Life House Friends, Inc which is a non-profit corporation. The purpose of Life house Friends is to raise funds to assist hospice residents that need

additional financial support and to help educate the communities, both residents and medical providers, about hospice services. Life House Friends, Inc has entered into a contract with Synergy to aid in our efforts to build and sustain funds to support our patients. The Gerharts have extensive background in both fund raising and in building volunteer groups to carry out mission activities.

7. Life House friends will, in conjunction with Life House, hold educational seminars through the volunteers with hospice background. The passion with our volunteers is overwhelming and contagious. We will be continuing to hold tours of the facility and be speaking at events, seminars and professional meetings to educate the medical professionals about the need and genuine service provided to end-of-life patients by residential hospice providers.

8. The ability to pay is not inhibiting our ability or willingness to provide services. The nonprofit support and our desire to serve all who have the need will be our guiding force. Life House, LLC and Life House Friends were born through the coming together of professional individuals of three large area Methodist churches, a Catholic church, a Morman congregation and a three thousand plus member Charismatic Fundamental church of our area. Our associates are mission motivated.

9. Our patient mix, from preliminary indications, will be more of the hard to serve that have been "falling through the cracks" under current services available. See, also, our comments in question 9 principal one regarding the particular difference of our service population from the state population figures.

10. We will work with the homeless shelters, churches and other civic organizations to insure that all with need will have our residential hospice services available to them.

11. All required data for the annual JAR, program planning and budgeting will be collected and compiled on an ongoing basis for accountability to the governing agencies and our director/shareholders.

10. Section C, Need, Item 3
The provided county map of Tennessee is noted. However, please submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on an 8 ½" x 11" sheet of white paper marked only with ink detectable by a standard photocopier.

See attachment 7, State of Tennessee County Service area map

11. Section C, Need, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Response:
See attachment 8, County Data requested

12. Section C, Need, Item 4.B.

Please describe any special needs of the service area population including health disparities, accessibility to services, women, racial and ethnic minorities, and low income groups. In your response, please document how the applicant will take into consideration the special needs of the service area population.

Response:
The residents of our proposed service have lower median household incomes than the State average, 20% have incomes below the poverty level and 21% are TennCare recipients. We will be contacting other service providers in our service area to offer our services to their patients, as well as, helping the residents apply for program such as Choices that are available to them.

Please indicate how this proposed project will benefit those patients and/or families without access to transportation that are in need of a local residential hospice.

Response:
Upper Cumberland Human Resources Agency (UCHRA) provides services to our entire proposed service area. These services include transportation services that are handicap accessible. We can arrange transportation through them for our patient's families. I have worked with them in the past and will make available their many other service to our residents and their families.

13. Section C, Need, Item 6

The provided projected utilization and/or occupancy statistics is noted. However, the methodology must include detailed calculations or documentation from referral sources.

Completing the charts below should assist in providing the requested details:

Response:
See attachment 9, Requested Tables 1 and 2

14. Section C, Economic Feasibility, Item 1
The residential appraisal is noted. The report notes the property is in FEMA (Federal Emergency Management Agency) flood zone "X". Please describe this designation and indicate the possible risk of flooding to the proposed project's location.

Response:
According to Fema this designation means moderate to low risk areas with hazard limits between 100 and 500 year flood plain. Notice the box checked was "no" as to Fema special flood hazard zone. **See Attachment 10, Definitions Fema Flood Zone Designations**

Please discuss why the applicant needed to receive special exception to be converted to a hospice residence home from the local board of zoning.

There was no provision in the zoning code in Putnam County for Residential Hospice when we initially inquired about the use. The code was created and we, then, applied for the exception created for RS-10 zoning allowing residential hospice.

15. Section C, Economic Feasibility, Item 2 (funding)
The letter from the applicant's CFO is noted. Please clarify if the $33,000 designated for start-up cost will come from the initial sale of shares in the corporation in the amount of $100,000.

Response:
The initial sale of shares is where the $33000 was generated.

The statement additional investors are ready to purchase shares in Life House, LLC in excess of $200,000 upon approval of the CON is noted. Please identify the additional investors and indicate the reason why there will be a need for additional investment. In addition, will this additional purchase of shares change the ownership structure of the LLC?

Response:
The additional investors are family members that share our calling and passion for this project. This sale may only be necessary to fund any delayed cash flow reimbursements through Medicare and TennCare. We understand that as a new provider delays are routine. Should a sale occur there will be no change in ownership over 4% and the current ownership will retain the majority shares.

16. Section C Economic Feasibility, Item 1 (Project Cost Chart)
The applicant has provided projects from 2007 to compare proposed project costs. Please compare the cost per square foot of construction to more recently similar approved projects such as CN0906-026A Hospice of Chattanooga, Inc. and CN0810-77A Hospice of Cumberland County d/b/a Cumberland House.

Response:
The cost per square foot for the new Cumberland House CN0810-77A was $134.08 for new construction and CN0810-77A Hospice of Chattanooga, Inc., the project per square foot cost was $388.36 for 16740 square feet of space. Our remodel cost has been only $24.49 per square foot and with our acquisition cost of $45000 for our 4450 square foot facility of $101.13 per square foot, gives us a total cost per square foot of $125.62 for our 10 bed facility..

17. Section C, Economic Feasibility, Item 4 (Projected Data Chart)
Please explain why there are no contractual adjustments.

Response:
We have no existing contracts at this time and no data to support adjustments.

Please clarify if salaries and wages in the amount of $310,897 includes 24 hour nursing care.

Response:
The salary and wages figure of $310,897 does include 24 hour nursing care.

Please clarify what the retirement of $250,000 in principal in Year Two represents.

Response:
The $250000 of principal in year two represents the plan to exercise the option to purchase the property in year two.

Please specify the unit of measure for line A. Utilization Data. Please revise and resubmit the Projected Data Chart.

Response:
See Attachment 11, Projected Data Chart

18. Section C, Economic Feasibility, Item 6.A
Please provide the proposed charge schedules for the proposal. Please also describe the anticipated revenue from the proposed project.

Response:
The proposed charge schedule is as follows for 2013:

Service	Patient Days	Rate	Revenue
Routine Care	615	$132	$ 81,180
General Inpatient	870	$593	$515,910
Respite Care	15	$141	$ 2960
Total	1500	$400 Av w/o charity	$600,050

Numbers compiled from 2011 JAR of Tn. Residential Hospices

Please clarify if room and board will be reimbursed by Medicare. If not, how is room and board paid? Please clarify which HCPCS Codes (Q5001-Q5009) will be billed to Medicare

Response:

Room and Board is not going to be paid by Medicare and will be provided by the families or our charity foundation. Room and board is not included in our projected revenue numbers. The HCPCS code Q 5006, patient care provided in an inpatient hospice facility will be billed to Medicare.

19. Section C, Economic Feasibility, Item 6.B
The average daily charge schedule is noted. Please provide the certificate of need number for each project and date approved by the agency.

Response:

Facility	CON number	Date Approved	Average Daily Charge w/charity 2011
Life House	Pending	---	$418 projected
Cumberland House	CN0810-77A	2010	$279
Hospice of Chattanooga	CN0906-26A	2011	$599
Residence at Alive	CN9612-074A	1997	$501
Wellmont	CN9312-062A	1994	$243

Health Service and Development Agency

Since the applicant will be providing care to Medicare recipients, please compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code (s).

Response:

FY2013HospicePaymentRatesBeforeWageAdjustment

Code	Description	Rate	Life House Rate	
651	Routine Home Care	$153.45	$132.00	
652	Continuous Home Care Full Rate = 24 Hours of	$895.56	0	
655	Inpatient Respite Care	$158.72	141.00	
656	General Inpatient Care	$682.59	$593.00	

Medicare billing data

20. Section C, Economic Feasibility, Item 7

Please discuss the methodology used to come to the conclusion utilization of 50% will be sufficient to breakeven in Year One and a utilization rate of 82% will generate a significant positive cash flow in Year Two of the proposed project.

Based on the average revenue per patient day, as reviewed above of the four existing residential hospices, and our anticipated expenses for Life House, we came to our conclusions on profitability. The charitable contributions do not exceed our net operating income and we would remain profitable with our projected bad debt and indigents. **See attachment 11, Revised Projected Data Chart**

21. Section C, Economic Feasibility, Item 8

The statement "we have numerous investors ready to purchase shares of the corporation, once the CON is approved, which will give us ample operating capital if required" is noted. Please provide letters of capital commitment from those investors and documentation of the available funds.

Response:
Our prospective investors are family members and friends who have express willingness to invest should the need arise. We have not sought letters of commitment or proof of funds pending the approval of the CON.

Life House Friends, Inc and Life House, LLC are applying for profit and non-profit grants through Synergy Funding Services and will continue to apply for grants and donations.

22. Section C, Economic Feasibility, Item 9

Please discuss how medically indigent patients will be served by the proposed project.

Response:
We have Life House Friends, Inc which is a nonprofit 501c3 corporation. This corporation has been formed specifically for raising funds to take care of indigent patients and to help care for the special needs of our end-of-life patients.

23. Section C, Economic Feasibility, Item 10
The attached balance sheets located in Attachment C. from Clenton Daniels, CPA is noted. Please define the following categories totaling $628,050 as listed under "Revenue": Routine Rate $424,196; In Patient $175,854; Private Donations; $500; Memorial donations; $2,500 and Auxiliary Donations. If needed, please revise the Projected Data Chart under "B. Revenue from Services to patients" that will possibly more accurately categorize revenue.

Response:
See attachment 11, Revised Projected Data Chart

Please clarify what Private, Memorial, and Auxiliary donations in the amount of $28,000 will be designated for. Also, are these donations recurring each year?

The Private donations are from people that individually wish to contribute to the hospice. Memorial donations are from the relatives of the deceased patients. Auxiliary contributions are from our foundation, Life House Friends, Inc that conduct fund raising activities to support our indigent patients and other patient needs. This will be an on-going contributor.

24. Section C, Economic Feasibility, Item 11
Please describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative. What were the alternatives considered prior to the building being completed and furnished?

Response:
Both the Mitchells and the Gerharts have incurred personal family hospice needs and have witnessed the needs of area residents and church needs for residential hospice services. These needs were ultimately resolved through travel to distant places or with the help of local home health or volunteers at great expense and effort. We looked for reasonable alternatives and found only in-home hospice care in our immediate area. As we spoke with area social workers at CRMC, Caris In-Home Hospice, NHC Home Health and the NHC nursing home we found there to be a group of patients, with no one to care for them in their homes, to be in need of another choice of a place to receive the care they need. Many times the nursing homes are unable to accommodate the short term hospice patient and there is not any other local alternative.

The Gerharts were exploring land purchase and new construction and the Mitchells, no longer needing the huge home for elderly parents, joined forces and the Life House project was born. After consulting with Michael Brady Architects, we were convinced that the former group home on State St in Cookeville was our most functional, most economical and swiftest answer to the residential hospice need in our community.

When we contacted the planning and zoning department in Cookeville, James Mills, the director, was delighted and felt that the use for this property was the highest and best use of the property and wrote their new zoning code accordingly.

We consulted with Ken Taylor from Cumberland House and he was very optimistic about our project and the need in our service area. He gave us many insights into the challenges of our undertaking. He continues to be very encouraging and supportive.

25. Section C, Orderly Development, Item 1
Please be more specific in responding to this question. Please list the names of all existing health care providers (e.g. hospitals, nursing homes, home care organizations, hospice providers, etc.), managed care organization, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services. Responding to the question by stating the applicant will work with three medical centers and unknown home health and hospice care givers is not an adequate response.

Response:
Since our Letter of Intent has been published, we have initiated the phase of our plan of contacting and interacting with the local medical community. Through personal contact and a series of open houses we have contacted the following organizations to discuss contracting and referrals:

Cookeville Regional Medical Center, Livingston hospital, Caris Home Health, Gentiva

Home Health, Avalon Home Health and Quality Home Health. We have spoken with many individual social workers from these organizations, medical doctors and other professionals and have met with "we have needed this service for a very long time." They are all excited to have residential hospice as a care option and have said they will refer qualified patients to our facility.

26. Section C, Orderly Development, Item 3

The overall staffing chart is noted. The FTEs in the chart total 7.4 while the narrative response list 8.65 FTE employees, please clarify.

Response:
The FTE 7.4 came from the chart providing salary comparisons of the staff providing patient care. The FTE 8.65 includes non patient care giving staff such as clerical, administrative and bookkeeping and is the total staffing for the facility.

Please clarify if a chaplain, dietician or bereavement counselor will be employed. If not, how will these professionals be accessed by patients?

Response:
We will have chaplain, dietician and bereavement counseling service available to our patients and their families. Richard Gerhart, holds an MA degree from Asbury Seminary in World Missions and Evangelism which contained bereavement counseling, and he is an ordained minister of the Wesleyan Church. He is a member of the Overton County Ministerial Association. Clergy from other ministries will be contacted as needed for individual patient preference. A dietician and dietary needs will be handled through an outside vendor and was included in our budget under Patient Expenses meals and food. Year one, we budgeted $8000 and year two, $16000.

Please discuss the rationale of paying registered nurses and a social worker under the median wage as provided by the State of Tennessee Department of Labor and Workforce Development.

Response:
We have the availability of many retired professionals including RNs, LPNs, CNAs, social workers and other workers including maintenance and grounds keeping. These folks have great skills and experience, want to make a little extra income and mostly want to be involved with and giving back to their communities. According to the Tennessee Department of Labor and Workforce in the program Senior Community Service Development Program (SCSEP), "Many Tennessee employers are hiring older workers as part of their recruitment efforts to use their skills, experience and talents they possess". Being four retirees ourselves, I think we can relate! **See Attachment 12, SCSEP information**

27. Section C, Orderly Development, Item 4
Please discuss the availability of registered nurses and a social worker while the applicant is planning to pay an hourly wage below the median hourly wage.

Response:
According to the SCSEP they pay in their program minimum wage of $7.25 per hour. We have volunteers as well that have offered services for the privilege of serving. Our support community is strong, we will meet our staffing numbers and figures.

Please clarify if the facility is required to provide 24 hour nursing care. If so, was this considered in developing the expected staffing pattern of the proposed project?

Response:
The facility will have 24 hour nursing staff available. Mrs. Gerhart is a Registered nurse and will be working in that capacity at the facility. She will oversee the nursing staff to insure excellent quality of care. Her shifts will be added to the nursing staff numbers for our 24 hour coverage.

What will be the shifts for medical staff?

Response:
Shifts of medical staff will be basically three shifts per day anticipated at 7-3, 3-11, and 11-7. It is planned that all fulltime employees will be scheduled on these shifts in order to develop consistent team work. Coverage of absences and downtime will be minimal as all the owners will be at least CNA certified, with one an RN and one a nursing home administrator.

Please indicate if a Medical Director has been identified. If so, please provide the name of the physician and documentation of his/her qualifications.

Response:
The Medical Director has not been identified. We are looking at the Physicians, PAs and RNs available in our area with hospice backgrounds. Once we are approved our expanded board will make the final decision.

28. Section C, Orderly Development, Item 7
The applicant notes the facility will be accredited by the Community Health Accreditation Program (CHAP). Please describe CHAP.

Response: SUPPLEMENTAL
Community Health Accreditation Program (CHAP) is an independent, not-for-profit, accrediting body for community-based health care organizations. Created in 1965, CHAP was the first to recognize the need and the value for accreditation in community-based care. CHAP is the oldest national, community-based accrediting body with more than 5000 agencies accredited nationwide.

Please indicate the total estimated accreditation cost (including application fees, yearly accreditation fees, site visit fees, etc.). Please clarify if the accreditation expense was accounted for in the projected data chart.

Response:
The Initial application has been submitted but the process is lengthy and not completed at a point in time until all of our licensing, approvals with Medicare etc, and facility inspections have been completed. This will take long enough that it is not a budget item at this time. The fee to initiate the application is $500, there are 3 site visits at a total cost of $2985, a three year accreditation fee of $4581 for a total cost from beginning to accreditation of $8066. This is our long term goal and we will work to accomplish it within the first three years.

We are joining the National Hospice and Palliative Care Organization, fee $555, and the Tennessee Hospice Organization, fee $300, once we are approved and licensed. These fees are in our marketing budget.

29. Project Completion Forecast Chart
The applicant has listed April 1, 2013 as the Agency projected Initial Decision date. The agency meeting for the month of April is scheduled for April 24, 2013. Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision to each phase of the completion forecast. Please adjust the Project Completion Forecast chart and resubmit.

Please clarify if the applicant is too ambitious in initiating service in April 2013 since the applicant must be Medicare certified in order to render care to Medicare and TennCare patients.

Response:
The Project Completion Forecast Chart has been adjusted to reflect the April 24 date and the 30 day time to become State licensed and for the Medicare/TennCare processing time of 6 weeks. Our opening as a residential hospice, fully licensed and functional has been changed to July 1, 2013. Perhaps we were too ambitious and need to practice the virtue of patience (usually not an entrepreneurial attribute)!!! **See attachment 13, Revised Project Completion Forecast Chart**

SUPPLEMENTAL

Attachment 1, Articles of Organization

SUPPLEMENTAL

Business Entity Detail

Entity details cannot be edited. This detail reflects the current state of the filing in the system.

Return to the Business Information Search.

Actions Available For This Entity:

File Annual Report | Update Mailing Address | Certificate of Existence | Change Registered Agent

000656664: Limited Liability Company - Domestic Printer Friendly Version

Name:	LIFE HOUSE, LLC		
Old Name:	AUTHOR DIRECT MARKETING, LLC		
Status:	Active	**Initial Filing Date:**	04/15/2011
Formed in:	TENNESSEE	**Delayed Effective Date:**	
Fiscal Year Close:	December	**AR Due Date:**	04/01/2013
Term of Duration:	Perpetual	**Inactive Date:**	
Principal Office:	570 STATE ST COOKEVILLE, TN 38501-3718 USA		
Mailing Address:	570 STATE ST COOKEVILLE, TN 38501-3718 USA		
AR Exempt:	No	**Obligated Member Entity:**	No
Managed By:	Member Managed	**Number of Members:**	4

Assumed Names | History | Registered Agent

Name	Status	Expires
No Assumed Names Found...		

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays

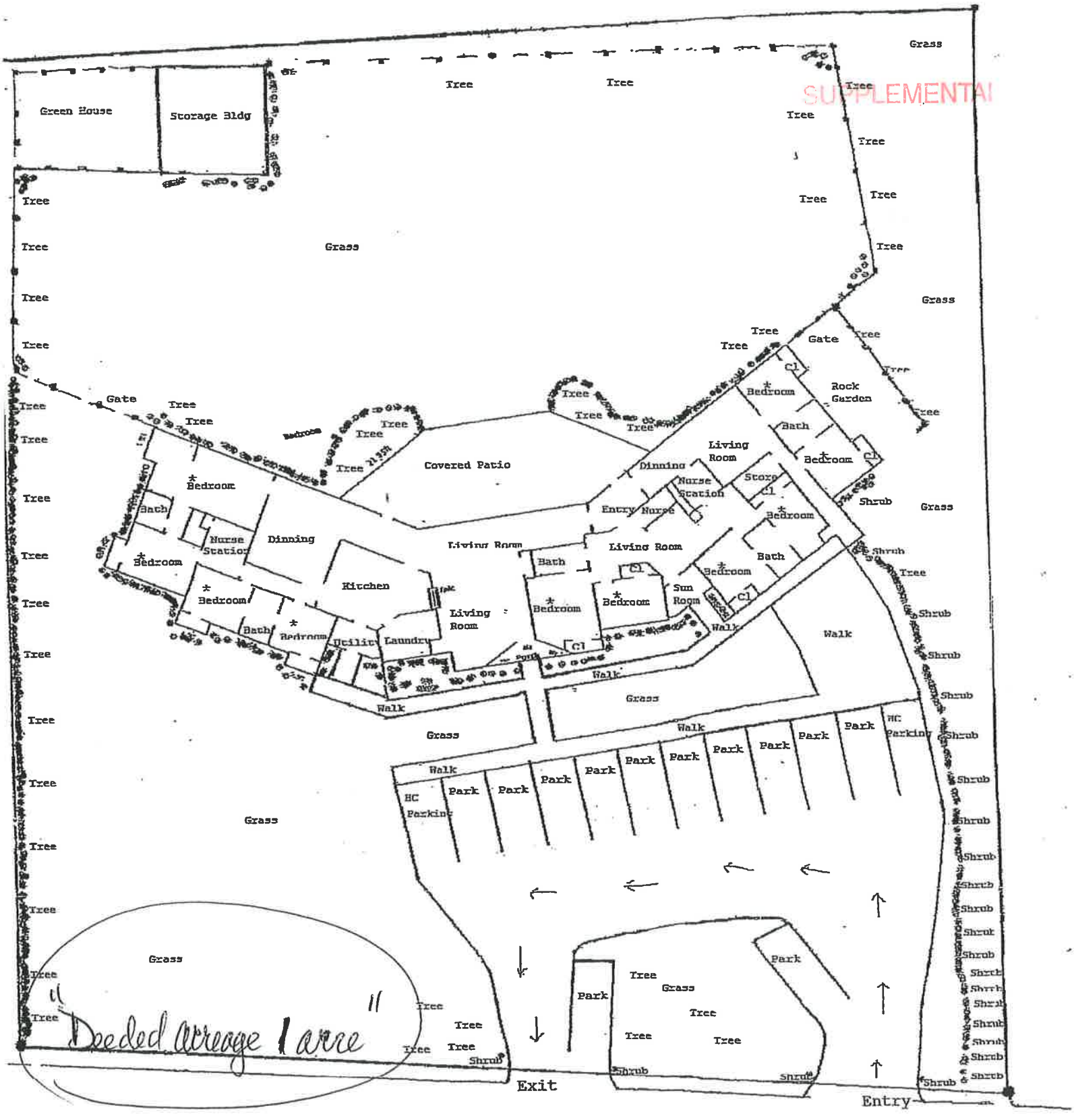
Attachment 2, Ownership Organization Chart

Life House, LLC
Ownership Organizational Chart

Connie Mitchell President 25%	Richard Gerhart, Vice President 25%	Jack Mitchell, CFO 25%	Sylvia Gerhart, Secretary 25%

SUPPLEMENTAL

Attachment 3, Floor Plan



570 STATE ST SITE PLAN LIFE HOUSE HOSPICE

CONNIE MITCHELL 881-6417

RICHARD BERHART 644-1785

24

— 6' Wood Privacy Fence

—— Property Line

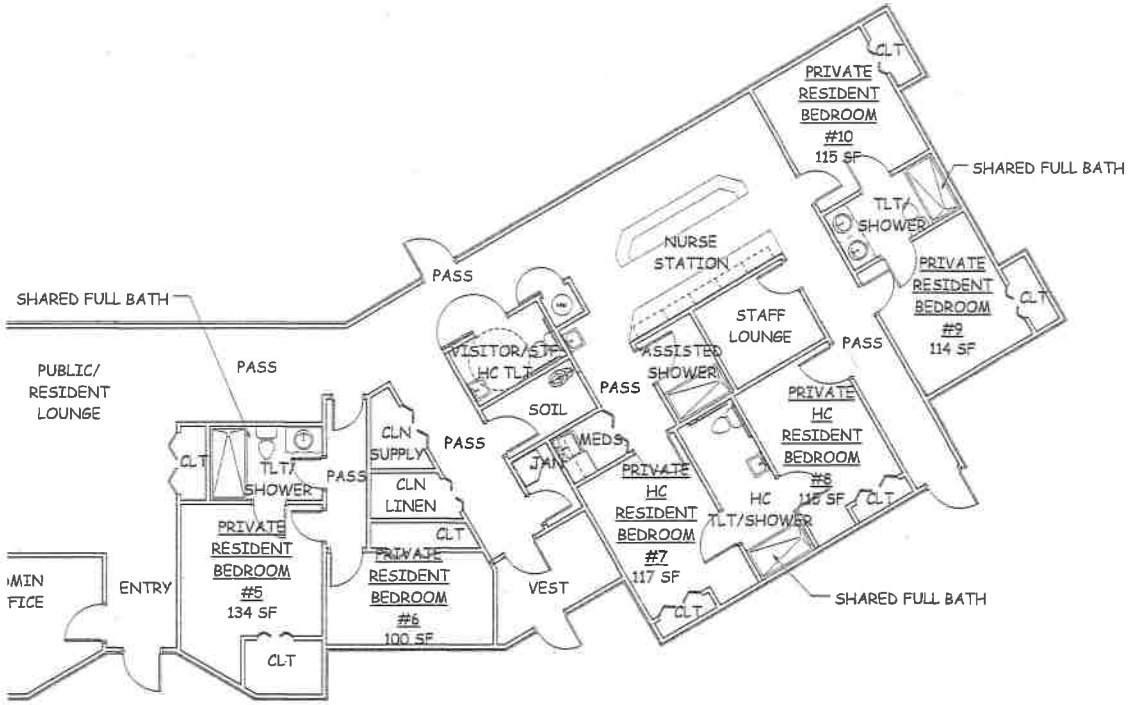
Attachment 4, Revised Cost per Square Foot

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
					4450		4450	109000		109000
B. Unit/Depart. GSF Sub-Total					4450		4450			
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF					4450		4450	$24.49		$24.49

SUPPLEMENTAL

Attachment 5, Revised Plot Plan – 1 Acre



COOKEVILLE TENNESSEE

REVISED 1/30/13

SUPPLEMENTAL

Attachment 6, Bed Need

The Tennessee Residential Hospice Bed Need Formula reflects the following need based on the preceding cancer statistics.

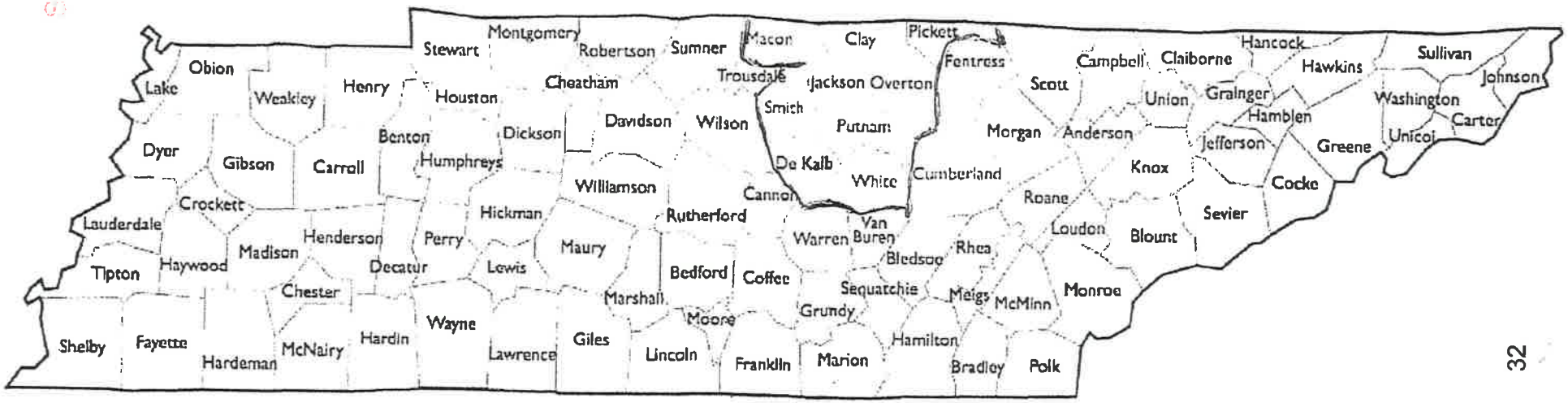
Bed Need

Non-cancer hospice usage	**2010 15%**	**2010 55.6%**	**2017 15%**	***2017 55.6%***
Cancer Deaths	493	493	528	***528***
Patient Hospice utilization 40%	198	198	212	***212***
Other users 15 and 55.6%	30	111	32	***119***
Total Hospice Users	228	309	244	***331***
Total hospice days = Users x average stay 45 days	10260	13905	10980	***14895***
Average daily hospice census = Total days divided by 365	29	39	31	***41***
20% average daily census (adc)	5.8 = 6	7.8 = 8	6.2=7	***8.2 = 9***
Bed need = adc divided by .85 occupancy	7.06	9.41	7.29	***10.59***
Bed Need	8	10	8	***11***

Attachment 7, State of Tennessee Revised Service Area Map

SUPPLEMENTAL

SUPPLEMENTAL



State of Tennessee

Attachment 7, Service Area Map

Attachment 8, Population Data Chart Requested

SUPPLEMENTAL

12. Attachment 8

Variable	Clay	DeKalb	Jackson	Macon	Overton	Pickett	Putnam	Smith	White	ServiceArea	Tennessee
2012(CY) Age 65+	1464	2914	1995	3083	3765	1101	11184	2636	4354	32496	878496
2013(PY) Age 65+	1500	2978	2061	3167	3850	1130	11542	2708	4467	33403	904587
Age 65+ %change	.98	.97	3.0	1.5	.30	2.6	3.2	2.7	2.6	2.8	3.0
Age 65+ %Total(PY)	18	15	18	13.5	18	22	15.8	13.3	17.4	16	14
2012 Total population	8201	19366	11419	23208	21377	5069	72489	20104	25521	206754	6,361,070
2013 Total population	8225	19529	11503	23452	21467	5107	73212	20330	25711	208536	6,414,297
Total Pop % change	0.3	1.0	1.0	1.0	0.4	0.7	1.0	1.1	0.7	0.9	0.8
TennCare Enrollees	1992	4354	2592	5796	4427	990	14258	3813	5796	44018	1,206,538
TennCare Enrollees %total pop	24.2	22.2	22.5	24.7	20.6	19.3	19.4	18.7	22.5	21.1	18.5
Median age years	46.0	40.2	44.1	37.5	41.7	44.5	35.9	39.2	41.1	39.1	37.8
Median Household Income $	28682	36870	32846	34747	34108	31157	34305	43580	34642	35130	43989
Population % below Poverty Level	20.0	18.5	22.9	23.9	19.8	16.3	24.9	17.2	20.8	20.0	16.9

Attachment 9, Requested Data Charts 1 & 2

SUPPLEMENTAL

Attachment 9

Table 1

Year	Admissions	Patient days	Average Daily Census	Average Length of Stay	Facility Occupancy
Year 1	34	1500	4	45 days	40%
Year 2	67	3000	8	45 days	80%

Table 2

Disease Classification	55 and younger	56-65	66-84	85 & older
Cancer	2	2	7	4
Heart Disease	1	1	3	2
General Debility				1
Dementia				
Lung Disease	1		2	
Stroke		1	2	1
Kidney Disease		1		1
Other			2	
Total	4	5	16	9

Attachment 10, Fema Information, flood plains

Attachment 11, Revised Projected Data Chart

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

		Year 2013	Year 2014
A.	Utilization Data (Specify unit of measure)Bed Days	1500	3000
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 515910	$1056166
2.	Routine	81180	167021
3.	Respite	2960	4913
4.	Other Operating Revenue (Specify)_Donations_____	28000	28000
	Gross Operating Revenue	**$ 628050**	**$ 1256100**
C.		Deductions from Gross Operating Revenue	
1.	Contractual Adjustments	$_____	$_____
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 11984**	**$ 23160**
NET OPERATING REVENUE		**$ 616066**	**$ 1232940**
D.	Operating Expenses		
1.	Salaries and Wages	$ 310897	$ 379769
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	40000	75000
4.	Taxes	0	0
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list) _____	$ 110400	143382
	Total Operating Expenses	**$ 541297**	**$ 693151**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 74769**	**$ 539789**
F.	Capital Expenditures		
1.	Retirement of Principal	$_____	$ 250000
2.	Interest	_____	_____
	Total Capital Expenditures	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 74769**	**$ 289789**

Attachment 12, Senior Community Service Employment Program (SCSEP) Data

Senior Community Service Employment Program participants receive an assessment to determine individual needs for training, supportive services, and potential for employment. Eligible participants are closely matched with their personal goals and placed in a position in community service (nonprofit, public, or private sector) for approximately 20 hours per week. Participants receive the federal minimum wage of $7.25 per hour. Other job-related training may consist of upgrading existing skills, developing new skills, limited educational opportunities, job counseling, and assistance in finding and keeping a job.

To gain work experience, Senior Community Service Employment Program participants are often placed in schools, hospitals, economic development iniative, weatherization activities, law offices, conservation programs, and many other sites. These sites translate into positions such as nurse's aides and teacher's aides, library clerks, clerical workers, adult and child day care assistants, campground recreational coordinators, maintenance workers, and many more occupations.

How Do I Apply?

To determine whether you are eligible for the Senior Community Service Employment Program, call the agency in your county and ask to speak with the "SCSEP Program Coordinator," who will do a brief "Question and Answer" evaluation over the phone to determine whether you qualify.

Click here to locate a SCSEP program near you (SCSEPContactList.shtml)

Reports, Plans, and Policies (SCSEPDocumenation.shtml)

Sub-grantees, Handbook

(SCSEPsubgrantees.shtml)

For additional information about the SCSEP program or to send comments, please contact:

TN Department of Labor and Workforce Development
Simi Atolagbe, Grants Program Manager
Senior Community Service Employment Program
220 French Landing Drive, 4B
Nashville,TN 37243
Phone: (615) 253-5869
Fax: (615) 741-3003

Attachment 13, Revised Completion Data

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

SUPPLEMENTAL

PROJECT COMPLETION FORECAST CHART

2013 JAN 31 PM 1 45

April 24, 2013 is the projected Initial Decision date, as published in T.C.A. § 68-11-1609(c):

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy		
10. *Issuance of license	45 days	06/2013
11. *Initiation of service	60 days	07/2013
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**
Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

SUPPLEMENTAL

AFFIDAVIT

2013 JAN 31 PM 1 45

STATE OF TENNESSEE

COUNTY OF PUTNAM

NAME OF FACILITY: LIFE HOUSE, LLC.

I, CONNIE MITCHELL after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Connie Mitchell
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31st day of January 2013, witness my hand at office in the County of Putnam, State of Tennessee.

NOTARY PUBLIC
Vickie Medley

VICKIE MEDLEY
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF PUTNAM

My commission expires
4/22/14

HF-0043

Revised 7/02

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm

January 30, 2013

2013 JAN 31 PM 1 44

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
500 Deaderick Street
Suite 850
Nashville, TN 37243

RE: Certificate of Need Application CN1301-001

Dear Mr. Earhart,

This will acknowledge the receipt on January 30, 2013 of your request for supplemental information for clarification and discussion.

Please accept the following as my response to each section referred to in your correspondence.

---

1. **Please re-submit the first supplemental response by typing each question and the response underneath. This includes responses to the Project specific criteria for Residential Hospice Services included in *Tennessee's Health: Guidelines for Growth's.* If there is a table in a response, please include the source of data underneath.**

Response: Resubmittal attached

2. Section B, Project Description, Item I.

Please clarify if it is a requirement of Medicare that you first need to be certified as a non-residential hospice or affiliated with a Medicare certified hospice to be eligible to apply for certification by Medicare as a residential hospice? Please contact the Tennessee Department of Health and provide the results of your contact.

Response:
I have contacted Ron Wood, a Medicare billing professional in Nashvile, he researched and found the following publications that clearly state the compliance standards to provide residential hospice services directly in your own facility with no affiliations, home hospice certification or prerequisites:

Attachment 1, Authenticated Government Information, 418.110 Condition of participation: Hospice that provide inpatient care directly.

Attachment 2, National Hospice and Palliative Care Organization, Medicare Hospice Conditions of Participation (COPS), SEC. 418.110 Hospices that provide Inpatient Care Directly

Attachment 3, State of Tennessee Department of Health, Residential Hospice Procedure for Applying for Licensure of a New Facility.

I have called Arthur Maples, as suggested, but he was out of the office.

The applicant states in the supplemental response "our CNA number includes LPNs and the pay is comparable". Please clarify how a CNA's pay is comparable to an LPN.

Response:
The median wage in Tennessee according to the Department of labor for LPNs is $17.12. The median for CNAs is $9.96. We used $12.00 in the CNAs category, which includes the LPN category, on the Hourly Wage Comparison page 34 of the original CON, for expected wage which accounts for the LPN slightly higher wage and the CNAs lower wage. As we discussed in question 27. Section C, Orderly Development, Item 4 of Supplement 1, we will be using retired staff that are willing to work for a lesser wage for the opportunity of employment and involvement. We are comfortable that we will meet our staffing requirements within our budget.

3. Section B, Project Description, Item IV. (floor plan)

The revised floor plan labels are too small to read. Please provide a revised floor plan that "zooms in" enough so that the room labels are readable. **See attachment 4, Floor Plan.**

Please answer the following questions in narrative form;

Please indicate the size of the patients rooms and if they will be private.

Response:
All rooms are 100 square feet or more and all will be private.

Please indicate if all the restroom facilities will be full baths. Will two patient rooms share a restroom?

Response:
All patient restrooms will be full baths and will be sharde by two residents.

Please indicate where the locations of the restroom facilities are for staff and visitors.

Response: A staff/visitors handicapped restroom facility is located adjacent to the main nurse station. This restroom does not have a shower.

The attached floor plan is labeled "Cookeville Adult Living Facility and Hospice, Cookeville, TN". Please clarify if the applicant plans to also provide services under the Adult Living Facility license. If not, please submit a replacement floor plan that is correctly labeled. If the applicant is planning to be also licensed as an adult living facility please discuss licensure requirements such as a firewall to separate units and a fire door.

Response:
It will not be an adult living facility and will be a residential hospice only, a new floor plan is attached.
See Attachment 4, Floor Plan

4. Section B, Project Description, Item II A.

The updated square footage and cost per square footage chart is noted. The applicant has noted the construction cost of $109,000 as the construction/renovation cost. Please clarify how this amount was calculated.

Response:
The cost was established by Michael Brady, Architect, see attachment C Economic Feasibility, 1 D-1, Architect letter in the original application. (Pages 71-73)

5. Section C, Need Item 1

The 5 Principles for Achieving Better Health responses are noted. Please clarify what the acronyms CAQH, CORE and UPD represent. What type of quality improvement program will the applicant adopt to continue to monitor and adhere to standards?

Response:
CAQH is a nonprofit alliance of health plans and trade associations, simplifying healthcare administration through industry initiatives that:

*Promote quality interactions between plans, providers and other stakeholders

*Reduce costs and frustrations associated with healthcare administration

*Facilitate administrative healthcare information exchange

*Encourage administrative and clinical data integration

Their vision is a healthcare system in which administrative processes are efficient, predictable, and easily understood by patients, caregivers and providers. In this system, administrative and clinical data are integrated to effectively support the delivery of care.

CAQH® serves as a catalyst for industry collaboration on initiatives that simplify healthcare administration, resulting in a better care experience for patients and caregivers. The Committee on Operating Rules for Information Exchange® (CORE®) is an initiative of CAQH that is bringing proven results to the industry.

CAQH CORE participating organizations include health plans representing more than 75% of commercially insured lives, plus Medicare and Medicaid beneficiaries.

The CAQH Universal Provider Data source (UPD) is the trusted source and industry standard for collecting provider data used in credentialing, claims processing, quality assurance, emergency response, member services and more. By streamlining data collection electronically, UPD is reducing duplicative paperwork and millions of dollars of annual administrative costs for one million physicians and other health professionals, as well as over 650 participating health plans, hospitals and healthcare organizations.

One of the quality improvement programs we will adopt is to be an active participant in NHPCO and follow their standards for compliance and systems improvement.

Hospice has seen rapid growth in recent years, but there is a lack of consistency among hospices when it comes to compliance with standards of care. Consequently, hospices vary in performance and in services they provide. With state hospice organizations, the NHPCO developed a National Data Set (NDS) intended to understand demographics, practices, and outcomes; illustrate industry effectiveness; facilitate communication of industry legislative needs; and to support agency performance and improvement.

6. Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Services

Question1: Residential Hospice Need formula.

- **The bed need formula in attachment 6 is noted. Please break out the need formula by county.**

Response:

County	CancerDeaths	40% Hospice utilization	Other users	Total users	Total days X45	Days divided by 365=adc	ADCx 20%	x.85 expected ccupancy	Bed need total
Clay	24	10	6	16	720	1.97	.39	0.46	
Dekalb	49	20	11	31	1395	3.82	.76	0.89	
Jackson	32	13	7	20	900	2.47	.49	0.58	
Macon	62	25	14	25	1755	4.81	.96	1.13	
Overtom	62	25	14	25	1755	4.81	.96	1.13	
Pickett	15	6	3	9	405	1.11	.22	0.26	
Putnam	166	66	37	103	4635	12.7	2.54	2.99	
Smith	50	20	11	31	1395	3.82	.76	0.89	
White	66	26	14	40	1800	4.93	0.99	1.16.	9.49

Bed need formula by county data 2017

- **Please indicate if the data source for cancer deaths were from Tennessee Department of Health Cancer Registry. If not, please calculate the residential need formula using official cancer registry data from the Tennessee Department of Health. Please indicate the latest year of data used.**

Response:

Revised Table 10
Cancer Death Data

County	2007 Cancer Deaths	2007 Population	Cancer Deaths/1000 %	2017 Projected Population	2017 Projected Cancer Deaths
Clay	23	7870	2.92	8318	24
DeKalb	45	18436	2.44	20161	49
Jackson	29	10791	2.68	11797	32
Macon	55	21561	2.55	24408	62
Overton	63	20795	2.85	21832	62
Pickett	14	4762	2.93	5221	15
Putnam	153	69916	2.18	76042	166
Smith	45	18845	2.38	21156	50
White	62	24895	2.49	26382	66
Total	489	197871		215317	526

TN Dept of Health Cancer Registry/US Census bureau

- **The Residential Hospice Guidelines indicate all figures are rounded off to whole numbers. If this is the case, in column 1 of the attachment, should 7.06 be rounded to 7 rather than 8?**
-

Response: See chart below Bed Need

- **Please explain in a narrative each column provided in Attachment- 6 Bed Need.**

Response:

1. Headings for 2007 and 2017 with each year reflecting other users at the assumed 15% and the current 55.6%.
2. The cancer deaths for 2007 by the TN dept of Health Cancer Registry and projected based on the 2007 death and population figure to 2017.
3. Patient hospice utilization at 40% of the cancer deaths.
4. Other users based by year and by the assumed 15% and the current usage of 55.6% based on the JAR 2011 statistics for other residential hospices.
5. Total hospice user for cancer and other causes based on the 15% and the current 55.6%
6. Total hospice days by an average stay of 45 days per hospice user, the uniform state standard for all counties.
7. Average daily census is the total hospice days divided by 365 days.
8. The inpatient bed is 20% of the average daily hospice census
9. divided by the expected occupancy rate which is .85
10. Bed Need rounded to the nearest whole number

The Tennessee Residential Hospice Bed Need Formula reflects the following need based on the preceding cancer statistics.

Bed Need

	2007 @ 15%	2007 @ 55.6%	2017 @ 15%	*2017 @ 55.6%*
1.Non-cancer hospice usage				
2.Cancer Deaths	489	489	526	*526*
3.Patient Hospice utilization 40%	196	196	210	*210*
4.Other users	29	109	32	*117*
5.Total Hospice Users	225	305	242	*327*
6.Total hospice days = Users x average stay 45 days	10125	13725	10890	*14715*
7.Average daily hospice census = Total days divided by 365	28	38	30	*40*
8. 20% average daily census (adc)	5.6 = 6	7.6 = 8	6	*8*
9.Bed need = adc divided by .85 occupancy	7.05	9.41	7.05	*9.41*
10.Bed Need	7	9	7	*9*

Question 2: Service Area

- **Why are the service area counties selected reasonable to which the applicant intends to provide services?**

Response:
The counties are reasonable because they are within a 50 mile distance from our facility. There is adequate transportation through the Upper Cumberland Human Resources Agency (UCHRA) and all the counties are in UCHRA which makes it a natural extension of existing services.

Question 4 a.: Please state why the population and Hospice bed formula supports the need for a 10 bed residential hospice. Please do not reference other parts of the application in addressing this criterion.

Response:
Based on the current usage figures for residential hospices in Tennessee and the population growth factors, our current need would, based on the 2007 Census population data, 9 beds. Considering our population growth of seniors and retirees being higher than the state average we need to anticipate growth. We are a 10 bed facility and the figures support our use now and room for future need without having to resubmit a CON for one bed.

Question 4 d.: Please provide how existing hospice providers and physicians will be expected to assist the residential hospice in referrals and coordination.

Response:
The existing in home hospice providers have patients they cannot serve because they have no available caregiver in their home. The providers all try, in the best interest of the patient to place them somewhere. Last week, the Caris Hospice and the hospital, CRMC, tried to place a patient with inadequate income and no care giver. They finally ended up sending him to Dickson away from everyone he knows and out of his comfort zone because there was no place here for him. Ms. Bowman, director of social workers at CRMC, has been very proactive in letting her staff, and other medical staff, know we are here. They are ready to use our services as soon as we are properly credentialed

Question 5: The statement "we will give routine care and hospice care in-house or under contract with the home hospice providers" is noted. Please clarify this statement. How would the applicant sub-contract with other hospice providers? Does the applicant intend to apply for the certificate of need for in-home hospice services too?

Response:
To clarify, we can provide the general day to day residential care giving for the other in-home hospice providers where they can still provide the hospice service and we can deliver care giver services for their patient. We will not apply for, nor do we wish to do, hospice care outside of our facility.

Question 9: Please address this question by not referring to other parts of the application. Please clarify how the applicant will ensure the patient case mix shall be reasonably

consistent with that of existing hospices in the service area and should not exclude hard-to-serve patients.

Response:
The case mix of the other hospice providers in our service area will be that of patients that are able to remain in their own homes. We will not service the patients that can remain in their own homes. Our patients are the patients that are now being forced out of our service area because of lack of adequate care facilities in our service area.

Question 10: The statement "our patient mix, from preliminary indications, will be more the hard to serve that have been falling through the cracks under current services available" is noted. Please provide an example of a patient who has fallen through the cracks in the proposed service area and not received the appropriate hospice level of service. Please do not use patient identifying information in your response. Also, please provide a description of what the applicant defines as a "hard to serve" patient.

Response:
Mr. Gerhart has a perfect example. He served for four years as the medical and financial power-of-attorney for a 63-67 year old male person who was "mentally handicapped" and recognized as such by social security. Mr. N lived most of his life in LA, California and was a former heroine addict with a history of marijuana, cocaine, LSD, alcohol and prescription drug abuse. He spoke English as a second language which complicated his comprehension when he was aroused. He had multiple ailments and eventually developed cancer of the liver and required transfusions and hospitalization. Six months prior to his death Mr. Gerhart, as the care giving became difficult at home, tried to find him a nursing home situation but was unsuccessful. There was no hospice in the area to take care of him when he could no longer stay at home. He was terrified to leave in his condition to go anywhere else. As we search we realized that he was not alone and many folks like him just slipped through the cracks in the system and ended up dying in fear. He was a very hard-to-serve patient that just needed a place to be where someone cared to help him through his difficulties. We did the best we could for him but we realized the need for end-of-life care is necessary service that is not available to many in need.

Question 11: Please list all items in this criterion and attest that the applicant will collect the requested data on an ongoing basis for accountability on program planning and monitoring budgetary priorities.

Response:

I attest that the following criteria will be collected on an ongoing basis for accountability on program planning and monitoring budgetary priorities:

Total number of clients seen annually
Number of clients by age, sex, race , diagnosis, and discipline
Number of clients by referral source
Average length of stay
Average daily census

Indicate the diagnosis for each patient ie. Cancer, aids, etc.
Total days of respite care and inpatient care
Site of death for all patients who die in the program
Average annual cost per patient per year

7. Section C, Need, Item 6

The provided table by clinical condition admission type for Year 1 is noted. It appears the applicant is projecting a majority of care will be provided to non-cancer patients in Year One. The applicant projects to provide care to 15 cancer patients and 20 non-cancer patients. Please clarify the methodology the applicant used to calculate these numbers. Also, how is the applicant in line with the hospice bed formula while the bed formula assumes other hospice users (non-cancer) is assumed to be 15% of the estimated cancer patients that utilize hospice services while the applicant projects 57% of patients in Year One will be non-cancer patients?

Response:
The methodology used was the same methodology used by Cumberland House on their Application for Certificate of Need. The mix of the other hospices on their JAR report from a prior year indicating that the Bed need formula assumption of 15% non-cancer users was, in reality, not accurate when comparing to the actual data as it is occurring in the hospice facilities around the State of Tennessee.

8. Section C, Economic Feasibility, Item 6.A

In the supplemental response, the applicant states room and board will be collected from patients. Collected room and board associated with the Residential Hospice is considered revenue. Please include the anticipated room and board charges in the projected data chart and submit a revised projected data chart.

Response: See Attachment 5, Projected Data Chart

The applicant has provided proposed charges compiled from the 2011 JAR of Tennessee Residential Hospices. Please clarify if these figures are before or after contractual adjustments. Please clarify how the applicant can use these figures while contractual adjustments in the projected data chart are unknown.

Response:
The figures used were before contractual adjustments.

9. Section C, Economic Feasibility, Item 6.B

The provided FY2013 Hospice Payment Rates Before Wage Adjustment Table is noted. Please indicate if these are Medicare rates.

Response:
They are Medicare rates.

10. Section C, Economic Feasibility, Item 10

The attached balance sheets located in Attachment C. from Clenton Daniels, CPA is noted. Please define the following categories totaling $628,050 as listed under "Revenue": Routine Rate $424,196; In Patient $175,854.

Response: This was redefined on the revised Projected Data Chart. **See Attachment 5, Projected Data Chart.**

Please clarify what Private, Memorial, and Auxiliary donations in the amount of $28,000 will be designated for. Also, are these donations recurring each year?

Response:
The donations will be used for indigent patients or as designated by the donor. These will be recurring.

11. Section C, Orderly Development, Item 3

The budgeted amount of $8,000 for Meals and Food in Year One is noted. This calculates to $7.30 per meal for the patient census. What other funding sources will be used to support this budget item? Please clarify if this amount is under budgeted.

Response: We will contract for food service with dietician on staff. In our investigation of services, we have been assured we will have donations to cover any overage. We, also, have room in our miscellaneous fund to cover overage in this category.

Please discuss the rationale of paying registered nurses and a social worker under the median wage as provided by the State of Tennessee Department of Labor and Workforce Development. Especially when the applicant states in the supplemental response" we are looking for physicians, PAs and RNs available in our area with hospice backgrounds".

Response: My terminology was misleading, I apologize. We are looking at (interviewing) not looking for (searching). We have a significant volunteer pool as we begin to staff at this wage level. As we grow we will be able, if appropriate, to increase our pay scale.

12. Section C, Orderly Development, Item 7

The accreditation expense of $8,066/00 is noted. Please clarify if the accreditation expense was accounted for in the projected data chart. If not, please include in the projected data chart and resubmit the projected data chart.

Response: We will not begin until 2014, I have added it to other expenses in the miscellaneous category. **See Attachment 5, Projected Data Chart.**

Attachment 1, Authenticated Government Information, 418.110 Condition of participation: Hospice that provide inpatient care directly.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospices.

(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship for the hospice, but only if the waiver would not adversely affect the health and safety of patients.

(3) The provisions of the adopted edition of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in hospices.

(4) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospice may place alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/codeoffederal_regulations/ibr_locations.html*. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the FEDERAL REGISTER to announce the changes.

(e) *Standard: Patient areas.* The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

(1) The hospice must provide—

(i) Physical space for private patient and family visiting;

(ii) Accommodations for family members to remain with the patient throughout the night; and

(iii) Physical space for family privacy after a patient's death.

(2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.

(f) *Standard: Patient rooms.* (1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients.

(2) The hospice must accommodate a patient and family request for a single room whenever possible.

(3) Each patient's room must—

(i) Be at or above grade level;

(ii) Contain a suitable bed and other appropriate furniture for each patient;

(iii) Have closet space that provides security and privacy for clothing and personal belongings;

(iv) Accommodate no more than two patients and their family members;

(v) Provide at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; and

(vi) Be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance.

(4) For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that—

(i) Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or

jeopardize its ability to continue to participate in the Medicare program; and

(ii) The waiver serves the needs of the patient and does not adversely affect their health and safety.

(g) *Standard: Toilet and bathing facilities.* Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.

(h) *Standard: Plumbing facilities.* The hospice must—

(1) Have an adequate supply of hot water at all times; and

(2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.

(i) *Standard: Infection control.* The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in §418.60.

(j) *Standard: Sanitary environment.* The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.

(k) *Standard: Linen.* The hospice must have available at all times a quantity of clean linen in sufficient amounts for all patient uses. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.

(l) *Standard: Meal service and menu planning.* The hospice must furnish meals to each patient that are—

(1) Consistent with the patient's plan of care, nutritional needs, and therapeutic diet;

(2) Palatable, attractive, and served at the proper temperature; and

(3) Obtained, stored, prepared, distributed, and served under sanitary conditions.

(m) *Standard: Restraint or seclusion.* All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

(2) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(3) The use of restraint or seclusion must be—

(i) In accordance with a written modification to the patient's plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy in accordance with State law.

(4) The use of restraint or seclusion must be in accordance with the order of a physician authorized to order restraint or seclusion by hospice policy in accordance with State law.

(5) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(6) The medical director or physician designee must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(7) Unless superseded by State law that is more restrictive—

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician authorized to order restraint or seclusion by hospice policy in accordance

those giving the training are documented; and

(6) A method for verifying that the requirements in paragraphs (c)(1) through (c)(5) of this section are met.

(d) *Standard: Inpatient care limitation.* The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.

(e) *Standard: Exemption from limitation.* Before October 1, 1986, any hospice that began operation before January 1, 1975, is not subject to the limitation specified in paragraph (d) of this section.

[73 FR 32204, June 5, 2008, as amended at 74 FR 39413, Aug. 6, 2009]

§418.110 Condition of participation: Hospices that provide inpatient care directly.

A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:

(a) *Standard: Staffing.* The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.

(b) *Standard: Twenty-four hour nursing services.* (1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

(c) *Standard: Physical environment.* The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.

(1) *Safety management.* (i) The hospice must address real or potential threats to the health and safety of the patients, others, and property.

(ii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.

(2) *Physical plant and equipment.* The hospice must develop procedures for controlling the reliability and quality of—

(i) The routine storage and prompt disposal of trash and medical waste;

(ii) Light, temperature, and ventilation/air exchanges throughout the hospice;

(iii) Emergency gas and water supply; and

(iv) The scheduled and emergency maintenance and repair of all equipment.

(d) *Standard: Fire protection.* (1) Except as otherwise provided in this section—

(i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: *http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the FEDERAL REGISTER to announce the changes.

with State law must see and assess the patient.

(ii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospice policy.

(8) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(9) The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (n) of this section at an interval determined by hospice policy.

(10) Physician, including attending physician, training requirements must be specified in hospice policy. At a minimum, physicians and attending physicians authorized to order restraint or seclusion by hospice policy in accordance with State law must have a working knowledge of hospice policy regarding the use of restraint or seclusion.

(11) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

(i) By a—

(A) Physician; or

(B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (n) of this section.

(ii) To evaluate—

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(12) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (m)(11)(i) of this section.

(13) If the face-to-face evaluation specified in § 418.110(m)(11) is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.

(14) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored—

(i) Face-to-face by an assigned, trained staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(15) When restraint or seclusion is used, there must be documentation in the patient's clinical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient's behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and the patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(n) *Standard: Restraint or seclusion staff training requirements.* The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) *Training intervals.* All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospice policy.

(2) *Training content.* The hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) *Trainer requirements.* Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

(4) *Training documentation.* The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(o) *Standard: Death reporting requirements.* Hospices must report deaths associated with the use of seclusion or restraint.

(1) The hospice must report the following information to CMS:

(i) Each unexpected death that occurs while a patient is in restraint or seclusion.

(ii) Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

(3) Staff must document in the patient's clinical record the date and time the death was reported to CMS.

§418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards.

(a) *Standard: Resident eligibility, election, and duration of benefits.* Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30.

(b) *Standard: Professional management.* The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §§418.100 and 418.108.

(c) *Standard: Written agreement.* The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services. The written agreement must include at least the following:

Attachment 2, National Hospice and Palliative Care Organization, Medicare Hospice Conditions of Participation (COPS), SEC. 418.110 Hospices that provide Inpatient Care Directly

National Hospice and Palliative Care Organization

Effective December 2, 2008

"COPS – PLANNING FOR SUCCESS" – MEDICARE HOSPICE CONDITIONS OF PARTICIPATION (COPS) BY TOPIC SERIES

§SEC. 418.110 CONDITION OF PARTICIPATION: HOSPICES THAT PROVIDE INPATIENT CARE DIRECTLY

Key points about this CoP:

★ Only key information and information about changes in the regulatory language is provided in this tip sheet. Detailed information about each standard can be located in the full language of 418.110. additional information is available at:
- NHPCO's webpage http://www.nhpco.org/i4a/pages/index.cfm?pageid=5709 or
- At the Federal Register at http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf

- A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:

(a) Standard: Staffing. The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.

(b) Standard: Twenty-four hour nursing services.

(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

(c) ***Standard: Physical environment.*** The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.

(d) Standard: Fire protection.

(1) Except as otherwise provided in this section—

(i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.

(e) ***Standard: Patient areas.*** The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

(1) The hospice must provide—

(i) Physical space for private patient and family visiting;

(ii) Accommodations for family members to remain with the patient throughout the night; and

(iii) Physical space for family privacy after a patient's death.

(2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.

(f) Standard: Patient rooms.

- Each patient's room must—
  - ✓ Accommodate no more than two patients and their family members For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that—
    - Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and
    - The waiver serves the needs of the patient and does not adversely affect their health and safety.

(g) *Standard: Toilet and bathing facilities.* Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.

(h) Standard: Plumbing facilities The hospice must –

(1) Have an adequate supply of hot water at all times; and
(2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.

(i) Standard: Infection control. The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in § 418.60.

(j) Standard: Sanitary environment. The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.

(k) Standard: Linen. The hospice must have available at all times a quantity of clean linen in sufficient amounts for all patient uses. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.

(l) Standard: Meal service and menu planning. The hospice must furnish meals to each patient that are—

- Consistent with the patient's plan of care, nutritional needs, and therapeutic diet;
- Palatable, attractive, and served at the proper temperature; and
- Obtained, stored, prepared, distributed, and served under sanitary conditions.

(m) Standard: Restraint or seclusion. (NOTE: *Access the Restraint and Seclusion information sheet for additional detail about this requirement)*

- In accordance with a modification to the patient's plan of care AND a physician's order (no standing orders or PRN).
- Implemented with safe techniques.
- **No more than 24 hours total**; renewed every 4 hours for adults
- Monitored by trained staff
- Face-to-face evaluation every hour for violent or self-destructive behavior.
- Staff trained before implementing seclusion or restraint techniques, at orientation, and on a periodic basis thereafter.
- Training addresses all relevant areas.
- Training documentation in personnel records.
- Report deaths associated with use of seclusion or restraint.
- Report deaths within 1 week of seclusion or restraint use when reasonable to assume a relationship.
- Report by phone to CMS no later than the close of the next business day after death; document reporting in patient's clinical record.

- ★ Be knowledgeable of and comply with any state licensure and survey requirements that may exist for inpatient facilities.
- ★ Review and revise current program policies/procedures to include new regulatory language.
- ★ Ensure that inpatient facility meets all requirements in the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).
- ★ See waiver process in preamble language for the patient room requirements in standard (f) if:
  - o it would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and
  - o The waiver serves the needs of the patient and does not adversely affect their health and safety.
- ★ Review the requirements for seclusion and restraint specifically to ensure that hospice staff are familiar with the requirements and what types of restraints are included.
- ★ Educate hospice staff about all new and revised policies, procedures, and processes.

Resources for success!

- NHPCO's Regulatory & Compliance Center – "CoP's – Planning for Success" campaign.
  - o www.nhpco.org/regulatory
- CMS – 2000 edition of Life Safety Code
  - o http://www.cms.hhs.gov/CFCsAndCoPs/07_LSC.asp

★ Please note that hospice providers need to comply with the most stringent regulatory requirements. (Federal or State)

References:

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; Final Rule, June 5, 2008
Web link: http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf

Attachment 3, State of Tennessee Department of Health, Residential Hospice Procedure for Applying for Licensure of a New Facility.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

RESIDENTIAL HOSPICE
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. You must first apply for a Certificate of Need (CON) from the Health Services and Developmental Agency prior applying for licensure of this type of facility. Once you obtain a CON you will need to submit a notarized application along with the appropriate licensure fee to the address at the top of the application.

2. Obtain architectural plans signed and sealed by an architect or Tennessee licensed engineer. Submit the plans to the Plans Review Section of Health Care Facilities. Once you receive approval of the architectural plans you may begin building the facility. If it is an existing building you will need to make any renovations that the plans reviewer has indicated. Approximately thirty (30) to forty-five (45) days prior to completion of the construction/renovations you will need to send a letter to the Regional Office in your area to request a survey of the facility. The Regional Office will notify you to schedule the survey. Be certain that you have given yourself plenty of time to have the building completed and to have your policies and procedures in order. If you are not ready on the date of survey it will most likely be thirty (30) days or more before the survey can be rescheduled.

3. Once the survey has been completed the surveyor will tell you if a recommendation is going to be made to license your facility. The surveyor will forward the appropriate forms to the Regional Office for the Regional Director's signature. The forms will then be forwarded to the Central Office Licensure Division in Nashville.

4. Licensure staff will then process the forms and send an initial approval letter to you. The application will then be presented to the Board for Licensing Health Care Facilities at the next regularly scheduled board meeting for ratification. If the Board ratifies the application the license will then be ordered from the computer center. You should receive the license in seven (7) to ten (10) days.

5. If the Board does not ratify the initial approval of your application, a letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/health. Please check this website periodically for updates.

PH-3508 (REV 01/09)

RDA-1165

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243
(615) 741-7221

RESIDENTIAL HOSPICE
APPLICATION FOR INITIAL LICENSURE

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/health. Please check this website periodically for updates.

Name of the Facility/Agency _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____ Total Bed Capacity _____

Administrator Information:

Administrator _____

Have you (administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement or fraud)? Yes ____ No ____

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building

Name _____ Phone (____) _____

Street _____

City _____ State _____ Zip _____

1. **Check Type:**

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm

a. Hospital Based _____ b. Nursing Home Based _____ c. Free Standing _____

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

Bed Capacity	Fee	Bed Capacity	Fee
Less than 25	$ 800	100 thru 124	$1,600
25 thru 49	$1,000	125 thru 149	$1,800
50 thru 74	$1,200	150 thru 174	$2,000
75 thru 99	$1,400	175 thru 199	$2,200

Facilities with 200 beds or more shall pay a flat rate of $2400 + $200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays $2,400; 225-249 pays $2,600).

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

_____ Individual _____ Partnership _____ Corporation _____ Limited Liability Company

_____ Church Related _____ Government/County _____ Other

b. Check One: _____ For Profit _____ Non-profit

c. Legal Entity Checked in 1.a:

Name _____ Phone (____) _____

Address _____

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

_____

Name Address City, State, Zip

_____

Name Address City, State, Zip

_____

Name Address City, State, Zip

(If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

Yes _____ No _____ Expiration Date _____

b. Is your facility/organization deemed by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

Yes _____ No _____ Expiration Date _____

3. If you have a parent company please provide the following information:

Name _____ Phone (____) _____

Address _____

4. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes _____ No ____

b. If yes, list names and addresses of all such facilities:

_____

_____

_____

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm

5. a. Do you have a contract with a management firm to operate this facility? Yes ___ No ___

If yes, specify dates: From _____ To _____

b. If yes, specify name of firm: _____

Phone (____) _____

Address: _____

6. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state? Yes _____ No _____

b. If yes, where? _____ When? _____

c. For what reason? _____

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

_____	_____	_____
Applicant Signature	Title or Position	Date

STATE OF TENNESSEE

County of _____

The above named applicant (print name) _____, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

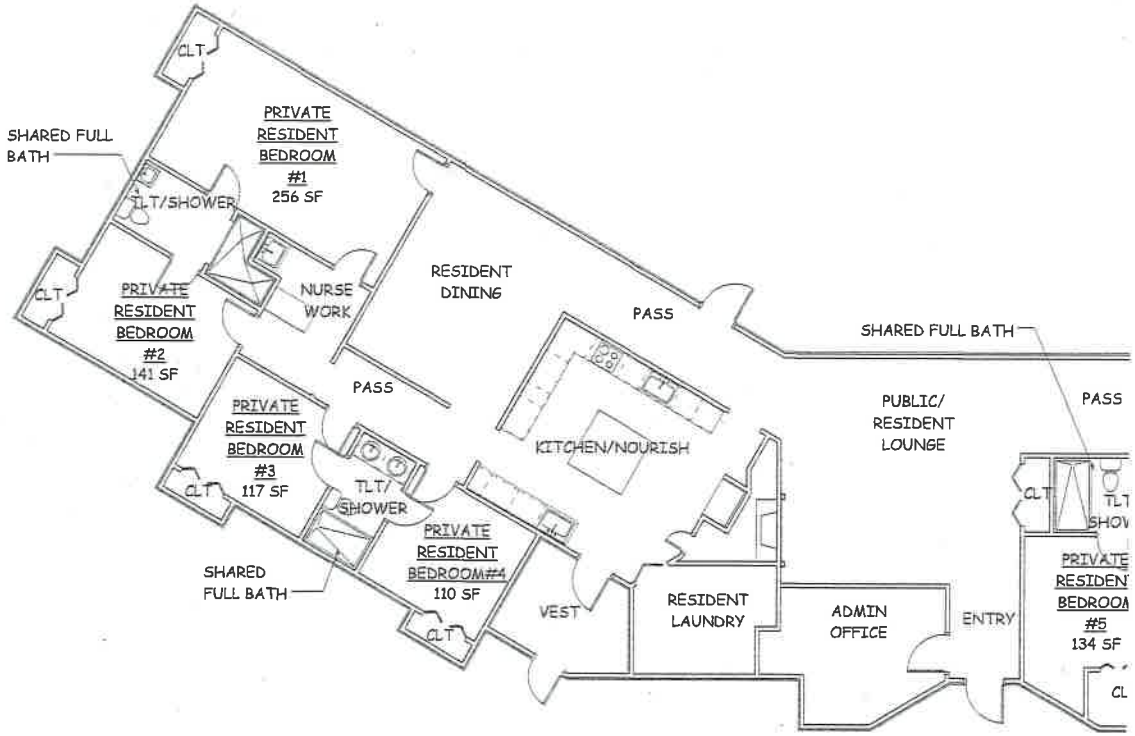
Subscribed to and sworn to before this _____ day of _____
(Month) (Year)

Notary Public: _____

My commission expires: _____

Attachment 4, Floor Plan

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm



MBI
michael brady inc.
architecture.engineering.interiors.

LIFE HOUSE, LLC
A RESIDENTIAL HOSPICE

MBI PROJECT #120393

Attachment 5, Revised Projected Data

SUPPLEMENTAL- # 2
January 31, 2013
1:45pm

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

2013 JAN 31 PM 1 44

		Year 2013	Year 2014
A.	Utilization Data (Specify unit of measure)Bed Days	1500	3000
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 515910	$1056166
2.	Routine	81180	167021
3.	Respite	2960	4913
	Other Operating Revenue (Specify)Donations/ room and board	73000	118000
	Gross Operating Revenue	**$ 673050**	**$ 1346100**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$	$
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 11984**	**$ 23160**
NET OPERATING REVENUE		**$ 661066**	**$ 1322940**
D.	Operating Expenses		
1.	Salaries and Wages	$ 310897	$ 379769
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	40000	75000
4.	Taxes	0	0
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list) _____	$ 110400	151448
	Total Operating Expenses	**$ 541297**	**$ 701217**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 119769**	**$ 621723**
F.	Capital Expenditures		
1.	Retirement of Principal	$	$ 250000
2.	Interest		
	Total Capital Expenditures	**$**	**$**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 119769**	**$ 371723**

Other expenses are:

Table 14
Other expenses

	Year 1	Year 2
Pharmacy, therapy, lab	$ 74800	$104682
Insurance	4000	4000
Utilities	8600	9600
General/office supplies	7000	8600
Contract laundry	2500	3000
Miscellaneous	13500	13500
Total	$110400	$143382

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: Since this application is for a new facility, current charges have not been established. First year gross revenue projections are expected to be $628050 or $418.70 per patient day.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Table 15

Average Daily Charge

Facility	Average Charge
Life House, LLC	418.70
Hospice of Cumberland County	552.00
Wellmont	584.00
Alive	658.00

Copy

Supplemental #3

Life House, LLC

CN1301-001

February 18, 2013

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

Phillip M. Earhart
Health Services Development Examiner
Health Services and Development Agency
161 Rosa Parks Blvd. 3rd Floor
Nashville, TN 37203

2013 FEB 21 PM 1 12

RE: Certificate of Need Application CN1301-001

Dear Mr. Earhart,

This will acknowledge the receipt on February 14, 2013 of your request for supplemental information for clarification and discussion.

Please accept the following as my response to each section referred to in your correspondence:

1. **Section B, Project Description, Item I.**

After discussions with various entities regarding the eligibility of receiving certification and receiving reimbursement from TennCare and Medicare, the applicant has three (3) options:

1) Resubmit volume and revenue information that excludes Medicare and TennCare projections,

2) Include signed and dated documentation from an authority at Medicare, TennCare, and/or the Tennessee Department of Health stating very clearly that licensed only as a residential hospice, Life House, LLC will be eligible for certification and thus reimbursement by Medicare and TennCare for hospice services provided

or

3) withdraw the application.

RESPONSE:

See attached letter from Tennessee Department of Health. Attachment 1.

1. **Section B, Project Description, Item I.**

The response to placing CNA's and LPNs in the same category using a median wage of $12.00 is noted. Please describe the pool and number of retired LPN's, RNs, and part-time social worker that will be willing to accept a below median wage.

RESPONSE:

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

I have reworked the numbers to include the medical staff at the median hourly wage. We have an owner who is an RN, one who is a CNT and a pharmacist and we are all taking necessary CNT training. The bookkeeping will, also, be done by owners. I have revised the projected data to reflect this information.

Revised Table 16

Hourly Wages Comparisons

POSITION	FTEs	HOURLY WAGE Expected	HOURLY WAGE Median
Registered Nurse	4.65	23.00	22.77
Hospice Aide (CNT)	1.50	10.00	9.96
Social Worker	.25	20.00	20.00
LPN	1.00	18.00	17.76

Tn. Department of Labor 2011 Statistics

Revised Table 17
Expected Staffing

POSITION	FTEs
Chief Executive Officer-Administrator	.50
Medical Director	.25
Social Worker	.25
Registered Nurse	4.65
Aides	1.50
LPN	1.00
Clerks/ receptionist/billing/bookkeeping	.50
Total	8.65

Revised Projected Data Chart explanation:

1. Please note the revised Projected Data Chart has been changed to reflect the correct days in each billing category. The years have been adjusted to reflect the delays we are encountering, so our first full year will be 2014.
2. Please note, also, that one RN salary ($47,840) and at least one CNT salary ($20.800), as well as, the bookkeeping will be done pro-bono by the owners.
3. I have added contract adjustments C.1 for any additional services we may require, occasionally, from another hospice provider. For example, a terminally ill patient decides to go home and needs home hospice services under our continuing care plan or a patient improves and goes to a nursing home where we would need to continue the care plan until discharged from hospice care.

REVISED PROJECTED DATA CHART

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

2013 FEB 21 PM 1 12

		Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure)Bed Days	2500	3300
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 341295	$ 450509
2.	Routine	306900	405108
3.	Respite	0	0
4.	Other Operating Revenue (Specify)Donations/ room and board	99984	130360
	Gross Operating Revenue	**$ 748179**	**$ 985977**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 24000	$ 36000
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 35984**	**$ 59160**
NET OPERATING REVENUE		**$ 712195**	**$ 962817**
D.	Operating Expenses		
1.	Salaries and Wages	$ 279897	$ 379768
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	25000	35000
4.	Billing fees	46000	60000
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list) *	$ 87941	113382
	Total Operating Expenses	**$ 518838**	**$ 683150**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 193357**	**$ 279667**
F.	Capital Expenditures		
1.	Retirement of Principal	$100000	$ 100000
2.	Interest		
	Total Capital Expenditures	**$ 100000**	**$ 100000**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 93357**	**$ 179667**

*Other expenses are:

Revised Table 14
Other expenses

	Year 1	Year 2
Pharmacy, therapy, lab	$ 52341	$74682
Insurance	4000	4000
Utilities	8600	9600
General/office supplies	7000	8600
Contract laundry	2500	3000
Miscellaneous	13500	13500
Total	$87941	$113382

2. **Section C, Need, Item 1a. Service-Specific Criteria, Residential Hospice Services**

   The Residential Hospice Need formula table is noted. The Residential Hospice Criteria states "Cancer death statistics to be used are from the most recent year" for the Tennessee Residential Bed Need formula. Please clarify the reason why the cancer deaths for each county was taken from 2017 cancer deaths column as listed in revised table 10 on page 5 of the #2 supplemental response.

   There appears to be an error in the table for step B in the Tennessee Residential Bed Need Formula submitted in supplemental #2. In addition, the applicant used 2017 population projections. Please complete the following table only using the most recent cancer registry information.

RESPONSE:

The four tables just preceding indicate the bed need formula with the latest figures available in the Tennessee Department of Health Cancer Registry from 2007. The data from 2007 in table 1 shows the Bed Need Formula as stated in the formula at 15 % non-cancer users. Table 2 shows the 2007 figures reflecting the Tennessee 2011 hospice other-user figures on the 2012 JAR reports. The aggregate figure from the 2012 JAR reports for inpatient hospices in Tennessee is 55.6 % other-users.

Tables 3 and 4 represent the 2017 bed need formula at 15% and 55.6% other-users but using projected cancer deaths for 2017 from the US Census 2017 projected population data in the original CON application.

The projections are applied to more accurately reflect the bed need in our service area now and into the future since we are in 2013 and our most recent cancer data to be used is back to 2007. The figures are not that radically different but do indicate a rising need from 8 to 10 beds. As indicated in the guidelines, the New York bed formula is to be used but components are to be adjusted to trends pertinent to our State and service area.

Table 1

Bed Need based on 2007 figures at 15% other users

County	Cancer Deaths	40% Hospice utilization	Other users 15%	Total users	Total days X45	Days divided by 365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	23	9	1	10	450	1.23	0.25	0.29	0.50
DeKalb	45	18	3	21	945	2.60	0.52	0.61	1.00
Jackson	29	12	2	14	630	1.73	0.35	0.41	0.50
Macon	55	22	3	25	1125	3.08	0.66	0.78	1.00
Overton	63	25	4	29	1305	3.58	0.72	0.85	1.00
Pickett	14	6	1	7	315	0.86	0.17	0.20	0.20
Putnam	153	61	9	69	3105	8.51	1.70	2.00	2.00
Smith	45	18	3	21	945	2.60	0.52	0.61	1.00
White	62	25	4	29	1305	3.58	0.72	0.85	1.00
Total	489	196	29	225	10125	27.77	5.61	7.94	8.00

Bed need formula by county cancer data 2007 from TN Dept of Health Cancer Registry

Table 2

Bed Need based on 2007 figures at 55.6% other users

County	Cancer Deaths	40% Hospice utilization	Other users 55.6%	Total users	Total days X45	Days divided by 365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	23	9	5	14	630	1.73	0.35	0.41	0.50
DeKalb	45	18	10	28	1260	3.45	0.69	0.81	1.00
Jackson	29	12	7	19	855	2.32	0.46	0.54	0.50
Macon	55	22	12	34	1530	4.19	0.84	0.99	1.00
Overton	63	25	14	39	1755	4.81	0.96	1.13	1.00
Pickett	14	6	3	9	405	1.12	0.22	0.26	0.22
Putnam	153	61	34	95	4275	11.71	2.34	2.75	3.00
Smith	45	18	10	28	1260	3.45	0.69	0.81	1.00
White	62	25	14	39	1755	4.81	0.96	1.13	1.00
Total	489	196	110	306	13770	37.73	7.55	8.86	9.00

Bed need formula by county cancer data 2007 from TN Dept of Health Cancer Registry

Table 3

Projected 2017 Bed Need At 15% other users

County	Cancer Deaths	40% Hospice utilization	Other users 15%	Total users	Total days X45	Days divided by 365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	24	10	2	12	540	1.48	0.30	0.26	0.50
DeKalb	49	20	3	23	1035	2.84	0.57	0.76	1.00
Jackson	32	13	2	15	675	1.85	0.37	0.49	0.50
Macon	62	25	4	29	1305	3.58	0.72	0.96	1.00
Overton	62	25	4	29	1305	3.58	0.72	0.96	1.00
Pickett	15	6	1	7	315	0.86	0.17	0.22	0.22
Putnam	166	66	10	76	3420	9.37	1.87	2.54	3.00
Smith	50	20	3	23	1035	2.84	0.57	0.76	1.00
White	66	26	4	30	1350	3.70	0.74	0.99	1.00
Total	526	211	33	244	10191	30.10	5.47	7.94	9.00

Bed need formula by county cancer data projected to 2017 from TN Dept of Health 2007 Cancer Registry and US Census projected population data

Table 4

Projected 2017 Bed Need at 55.6% other users

County	Cancer Deaths	40% Hospice utilization	Other users 55.6%	Total users	Total days X45	Days divided by365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	24	10	6	16	720	1.97	.39	0.46	0.50
DeKalb	49	20	11	31	1395	3.82	.76	0.89	1.00
Jackson	32	13	7	20	900	2.47	.49	0.58	1.00
Macon	62	25	14	39	1755	4.81	.96	1.13	1.00
Overton	62	25	14	39	1755	4.81	.96	1.13	1.00
Pickett	15	6	3	9	405	1.11	.22	0.26	0.50
Putnam	166	66	37	103	4635	12.7	2.54	2.99	3.00
Smith	50	20	11	31	1395	3.82	.76	0.89	1.00
White	66	26	14	40	1800	4.93	0.99	1.16.	1.00
Total	526	211	117	328	14060	38.52	7.70	8.36	10.0

Bed need formula by county cancer data projected to 2017 from TN Dept of Health 2007 Cancer Registry and US Census projected population data

Taken from TN Guidelines for Growth for reference purposes only to support future upward trending population and need:

2. The Tennessee formula utilizes the format of the New York State Residential Hospice Bed Need Formula. However, the components of the Tennessee formula are based on health statistics and/or health trends pertinent to the State of Tennessee. Statistics to be used in this formula will be obtained from the Tennessee Department of Health.

SUPPLEMENTAL- # 3

Note 1, I have included in the corrected pages a revised Projected Completion Forecast Chart. **February 21, 2013 1:12pm**

Note 2, the corrected pages to insert into the original CON are at the end of this response. Attachment 2, Corrected Pages.

Please let me know if we need anything further. Thanks.

Respectfully,

Constance J. Mitchell
President/Director

Attachment 1
Medicare Certification

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No.0938-0313

INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES:

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Return the original and first two copies to the State Agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State Agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Item I:

- Request to establish eligibility in—current Hospice Benefits are available only through the Medicare program.
- Medicare certification number:
  Insert the facility's six digit Medicare Certification Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes:
  Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related certification number:
  If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Certification Number.

Item IV:

- If a service is provided directly by the facility place a "1" the appropriate block.
- If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0313

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice

Street Address

Request to Establish Eligibility In
1. ☐ Medicare
PH1

City, County and State

Zip Code

Medicare/Certification Number
PH2

State/County
PH3

State/Region
PH4

Telephone Number *(include area code)*
PH5

Related Certification Number
PH6

II. Type of Hospice *(Check One)*
PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*
A. ☐ The Joint Commission Accredited
B. ☐ AOA Accredited
C. ☐ Both The Joint Commission and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)*
PH8

Non-Profit:
1. ☐ Church
2. ☐ Private
3. ☐ Other

Proprietary:
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

Government:
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County

12. ☐ Combination Government and Nonprofit
13. ☐ Other

IV. Services Provided:
By staff, place a "1" in the block(s)
If under arrangement, place a "2" in the block(s)
PH9

Core:
1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services

5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Hospice Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care
12. ☐ Other(Specify)

PH10
A. _____Acute
B. _____Respite

Name and Address of Contractee

Medicare Certification/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent
Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18)

Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses PH13		Medical Social Workers PH14		Total Number PH19	
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		
Homemakers PH15		**Hospice Aide PH16**		**Counselors PH17**		**Others PH18**		Employees	Volunteers
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	A.	B.

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20

Form CMS-417 (08/10)

Attachment 2
Revised pages

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

Table 1

Bed Need based on 2007 figures at 15% other users

County	Cancer Deaths	40% Hospice utilization	Other users 15%	Total users	Total days X45	Days divided by 365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	23	9	1	10	450	1.23	0.25	0.29	0.50
DeKalb	45	18	3	21	945	2.60	0.52	0.61	1.00
Jackson	29	12	2	14	630	1.73	0.35	0.41	0.50
Macon	55	22	3	25	1125	3.08	0.66	0.78	1.00
Overton	63	25	4	29	1305	3.58	0.72	0.85	1.00
Pickett	14	6	1	7	315	0.86	0.17	0.20	0.20
Putnam	153	61	9	69	3105	8.51	1.70	2.00	2.00
Smith	45	18	3	21	945	2.60	0.52	0.61	1.00
White	62	25	4	29	1305	3.58	0.72	0.85	1.00
Total	489	196	29	225	10125	27.77	5.61	7.94	8.00

Bed need formula by county cancer data 2007 from TN Dept of Health Cancer Registry

Table 2

Bed Need based on 2007 figures at 55.6% other users

County	Cancer Deaths	40% Hospice utilization	Other users 55.6%	Total users	Total days X45	Days divided by 365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	23	9	5	14	630	1.73	0.35	0.41	0.50
DeKalb	45	18	10	28	1260	3.45	0.69	0.81	1.00
Jackson	29	12	7	19	855	2.32	0.46	0.54	0.50
Macon	55	22	12	34	1530	4.19	0.84	0.99	1.00
Overton	63	25	14	39	1755	4.81	0.96	1.13	1.00
Pickett	14	6	3	9	405	1.12	0.22	0.26	0.22
Putnam	153	61	34	95	4275	11.71	2.34	2.75	3.00
Smith	45	18	10	28	1260	3.45	0.69	0.81	1.00
White	62	25	14	39	1755	4.81	0.96	1.13	1.00
Total	489	196	110	306	13770	37.73	7.55	8.86	9.00

Bed need formula by county cancer data 2007 from TN Dept of Health Cancer Registry

Revised
22

Table 3

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

Projected 2017 Bed Need At 15% other users

County	Cancer Deaths	40% Hospice utilization	Other users 15%	Total users	Total days X45	Days divided by 365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	24	10	2	12	540	1.48	0.30	0.26	0.50
DeKalb	49	20	3	23	1035	2.84	0.57	0.76	1.00
Jackson	32	13	2	15	675	1.85	0.37	0.49	0.50
Macon	62	25	4	29	1305	3.58	0.72	0.96	1.00
Overton	62	25	4	29	1305	3.58	0.72	0.96	1.00
Pickett	15	6	1	7	315	0.86	0.17	0.22	0.22
Putnam	166	66	10	76	3420	9.37	1.87	2.54	3.00
Smith	50	20	3	23	1035	2.84	0.57	0.76	1.00
White	66	26	4	30	1350	3.70	0.74	0.99	1.00
Total	526	211	33	244	10191	30.10	5.47	7.94	9.00

Bed need formula by county cancer data projected to 2017 from TN Dept of Health 2007 Cancer Registry and US Census projected population data

Table 4

Projected 2017 Bed Need at 55.6% other users

County	Cancer Deaths	40% Hospice utilization	Other users 55.6%	Total users	Total days X45	Days divided by365 = ADC	ADC x 20%	/.85 expected occupancy	Bed need Total rounded
Clay	24	10	6	16	720	1.97	.39	0.46	0.50
DeKalb	49	20	11	31	1395	3.82	.76	0.89	1.00
Jackson	32	13	7	20	900	2.47	.49	0.58	1.00
Macon	62	25	14	39	1755	4.81	.96	1.13	1.00
Overton	62	25	14	39	1755	4.81	.96	1.13	1.00
Pickett	15	6	3	9	405	1.11	.22	0.26	0.50
Putnam	166	66	37	103	4635	12.7	2.54	2.99	3.00
Smith	50	20	11	31	1395	3.82	.76	0.89	1.00
White	66	26	14	40	1800	4.93	0.99	1.16.	1.00
Total	526	211	117	328	14060	38.52	7.70	8.36	10.0

Bed need formula by county cancer data projected to 2017 from TN Dept of Health 2007 Cancer Registry and US Census projected population data

Revised

22 EXTRA INFO

REVISED PROJECTED DATA CHART

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

2013 FEB 21 PM 1 13

		Year 2014	Year 2015
A.	Utilization Data (Specify unit of measure)Bed Days	2500	3300
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 341295	$ 450509
2.	Routine	306900	405108
3.	Respite	0	0
4.	Other Operating Revenue (Specify)Donations/ room and board	99984	130360
	Gross Operating Revenue	**$ 748179**	**$ 985977**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 24000	$ 36000
2.	Provision for Charity Care	9045	17530
3.	Provisions for Bad Debt	2939	5630
	Total Deductions	**$ 35984**	**$ 59160**
NET OPERATING REVENUE		**$ 712195**	**$ 962817**
D.	Operating Expenses		
1.	Salaries and Wages	$ 279897	$ 379768
2.	Physician's Salaries and Wages	35000	50000
3.	Supplies	25000	35000
4.	Billing fees	46000	60000
5.	Depreciation	0	0
6.	Rent	45000	45000
7.	Interest, other than Capital	0	0
8.	Other Expenses (See list) *	$ 87941	113382
	Total Operating Expenses	**$ 518838**	**$ 683150**
E.	Other Revenue (Expenses) -- Net (Specify)	$ 0	$ 0
NET OPERATING INCOME (LOSS)		**$ 193357**	**$ 279667**
F.	Capital Expenditures		
1.	Retirement of Principal	$100000	$ 100000
2.	Interest		
	Total Capital Expenditures	**$ 100000**	**$ 100000**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 93357**	**$ 179667**

Revised

*Other expenses are:

Revised Table 14
Other expenses

	Year 1	Year 2
Pharmacy, therapy, lab	$ 52341	$74682
Insurance	4000	4000
Utilities	8600	9600
General/office supplies	7000	8600
Contract laundry	2500	3000
Miscellaneous	13500	13500
Total	$87941	$113382

Revised

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

Revised Table 16

Hourly Wages Comparisons

2013 FEB 21 PM 1 13

POSITION	FTEs	HOURLY WAGE Expected	HOURLY WAGE Median
Registered Nurse	4.65	23.00	22.77
Hospice Aide (CNT)	1.50	10.00	9.96
Social Worker	.25	20.00	20.00
LPN	1.00	18.00	17.76

Tn. Department of Labor 2011 Statistics

Revised Table 17
Expected Staffing

POSITION	FTEs
Chief Executive Officer-Administrator	.50
Medical Director	.25
Social Worker	.25
Registered Nurse	4.65
Aides	1.50
LPN	1.00
Clerks/ receptionist/billing/bookkeeping	.50
Total	8.65

Revised

33 + 34

SUPPLEMENTAL- # 3

February 21, 2013
1:12pm

PROJECT COMPLETION FORECAST CHART

May 22, 2013 is the projected Initial Decision date, as published in T.C.A. § 68-11-1609(c):

2013 FEB 21 PM 1 13

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy		
10. *Issuance of license	60 days	08/01/2013
11. *Initiation of service	60 days	08/01/2013
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Revised

SUPPLEMENTAL- # 3
February 21, 2013
1:12pm

AFFIDAVIT

STATE OF TENNESSEE 2013 FEB 21 PM 1 13

COUNTY OF Putnam

NAME OF FACILITY: Life House, LLC

I, Connie Mitchell, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Connie Mitchell
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 21st day of February 2013, witness my hand at office in the County of Putnam, State of Tennessee.

Jenny L. Wilson
NOTARY PUBLIC

JENNY L. WILSON
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF PUTNAM

My commission expires 6/21, 2016.

HF-0043

Revised 7/02

2013 JAN 23 AM 7:38

State of Tennessee
Health Services and Development Agency
161 Rosa Parks Blvd
Nashville, TN 37243

Dear Mr. Farber,

I would like to express to you, and the review committee, my support of the residential hospice project of Life House, LLC. in Cookeville, TN. I have been active in the healthcare community in the Putnam County area for some years, and can attest to the need for the hospice care in a residential, non-institutional setting. The hospitals and nursing homes, though excellent, cannot offer the personal services needed, and available through residential care, during the end of life journey.

Please give Life House Residential Hospice every opportunity. We have people waiting for this option to be available for their loved ones. Tennessee needs more residential hospices to align ourselves with other areas in providing services for this growing need and to offer better healthcare choices to our residents when facing these difficult family times.

Thank you for your consideration.

Sincerely,

Anne M. Barker APRN

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

May 1, 2013

Connie Mitchell, President
Life House, LLC
570 State Street
Cookeville, TN 38501

RE: Life House, LLC - Certificate of Need CN1301-001
Establishment of a 10 bed residential hospice facility. The proposed service area is Clay, Dekalb, Jackson, Macon, Overton, Pickett, Putnam, Smith and White counties.

Dear Ms. Mitchess:

This is to notify you that the referenced application is scheduled to be acted upon by the Agency at its next monthly meeting in Nashville on Wednesday, May 22, 2013, beginning at 8:30 A.M. The meeting will be held at the following location:

Legislative Plaza, Room 12
Sixth Avenue North & Union Street
Nashville, TN

Please be present and prepared to make a brief presentation and to respond to any questions regarding the application. Your presentation should address the following:

- Why the project is needed to provide necessary health care in the service area;
- How it can be economically accomplished and maintained; and,
- Its contribution to the orderly development of adequate and effective health care facilities and/or services.

In its review of the project, the Agency will weigh and consider the health care needs of consumers, particularly women, racial and ethnic minorities, TennCare or Medicaid recipients and low income groups. The applicant's current and future commitment to TennCare and any contractual agreements should be disclosed if applicable to the type facility or service sought.

Should you desire that Agency members receive information that has not been previously submitted, please forward twenty-four (24) copies of the information to this office by noon on **May 8, 2013.**

Meeting procedure information is enclosed for your review. Please call if you have any questions.

Sincerely,

Melanie M. Hill
Executive Director

MMH/AS
Enclosure

DIA

DANIELS, IRWIN & AYLOR CERTIFIED PUBLIC ACCOUNTANTS

Health Services Development Agency
500 Deaderick Street, Suite 850
Nashville TN 37243

RE: Lifehouse, LLC
Richard Gerhart

To whom it may concern:

I have known Richard Gerhart and his wife, Sylvia, since 2009. I am happy to have the opportunity to write a letter of reference on his behalf, as I have seldom in my life met one of such fine character with great compassion in his heart for his fellow man.

Richard and his wife were co-directors of the Good Samaritan Center in Livingston, Tennessee, operated by the Overton County Ministerial Association. Under their direction, the Center provided an outlet for the community to dispose of unwanted household items that were then re-distributed to those in need or sold to purchase food and personal items that were provided for those same down on their luck individuals. This couple has always been aware that sometimes, everyone needs a helping hand. Richard's ability to operate this Center as a business allowed many to be served making the ministry a success.

Mr. Gerhart, a pharmacist by trade, once owned 5 pharmacies in Pennsylvania. He then worked for a large pharmaceutical corporation, serving in many capacities and management positions. Then he changed directions, attending Asbury Seminary in Wilmore, Kentucky, to become an ordained minister.

I am not surprised to hear that Richard is applying for a certificate of need for a residential hospice house. Much of his life has been dedicated to creating entities to serve others, having run homes for those with substance abuse, worked with orphanages, and been a guiding light for those recently released from prisons.

Richard Gerhart has the character, heart, and skills to be a success in whatever manner he chooses to serve: To assist those with end of life care is an area in which I know he would shine. Thank you for this opportunity to tell you about someone for whom I have the utmost respect.

Sincerely,

Cleston B. Daniels, CPA

223 Madison Street, Suite 112 Madison, TN 37115-3660 (615) 868-6008 FAX (615) 868-2071
An Association of CPA's

OVERTON FAMILY MEDICAL CENTER

Trueman D. Smith, MD
Family Medicine

529 Medical Drive, Ste B
Livingston, TN 38570

Tel: (931) 823-1266
Fax: (931) 823-7805

January 28, 2013

State of Tennessee
Health Services and Development Agency
161 Rosa Parks Blvd
Nashville, TN 37243

Dear Mr. Farber,

I fully support the certificate of need for Life House, LLC, a new residential hospice for Putnam and surrounding counties.

As a practicing physician in these counties, I feel strongly that there is a great need for this facility. End of life issues, especially for those with no family, or family unwilling to help, are poorly handled in nursing homes and hospitals. Specialty Hospice solutions for these individuals are very important and badly needed.

I believe that this potential location is well suited to the Upper Cumberland and can do much good.

I strongly encourage that the certificate of need be granted so that this important work can begin as soon as possible.

Sincerely,

Dr. Trueman D. Smith
jab

FIRST
UNITED
METHODIST
CHURCH

2013 JAN 22 AM 6:58

To whom it may concern;

It is with a deep sense of joy that I recommend to you the ministry, the vision, and the character of both Richard (Dick) and Sylvia Gerhart. I have known these two for several years (almost a decade) and have seen them work in a variety of ways. They come to every project with extraordinary vision, vigor, and vitality, but even more so, with values—strong moral and faith-based values—all wrapped up in a strong work ethic.

Dick brings his years of experience in the pharmaceutical industry; Sylvia's contributions include her years of caring as a registered nurse. Together, they bring amazing wisdom combined with strength uncommon for people even half their age. I watched them for years, as the President of the Overton County Ministerial Association, do remarkable things. They birthed and operated our Good Samaritan ministry which grew dramatically under their tutelage, helping to clothe and feed a thousand people a month. All this was done on an embarrassingly small shoestring of a budget—a few hundred dollars a month. These folks don't waste a cent, and are scrupulously careful with the funds entrusted to them! At the same time, they started a ministry of outreach to the homeless and to those being released from the local prison. Everything they did they did with excellence. Every life they touched was touched by excellence. Every decision they made was approved by the Ministerial Association, because they turned twenty years of good wishes and talk into powerful ministries within a few months. We are forever in their debt!

This area desperately needs the Hospice they envision, and no one I am aware of could take such a vision from concept to reality quicker, more efficiently, or more professionally than Dick and Sylvia Gerhart. They bring such unique gifts to the table, and such uncommon passion! I cannot overstate what a rare and precious find they are, or how perfect the hospice plan is for our area of the state! I ask—even beg—you to give them the most careful, prayerful, and thorough hearing possible!

Your brother by the Blood,

Rev. Dr. Craig A. Green, Senior Pastor

www.drcraiggreen.com

104 Roberts Street, Livingston, TN 38570 • (931) 823-6445 • www.livingstonfirstchurch.com • e-mail: livingstonfirstchurch@twlakes.net